2851 Joe DiMaggio Blvd.
Bldg 8 unit-15
Round Rock, Texas 78665 **Modivcare.com**

Dear Individual Transportation Participant,

On behalf of Modivcare, I welcome you as a potential Individual Transportation Participant(ITP) and hope you will find providing transportation services rewarding.

Enclosed are the following enrollment items needed to complete the application process:

- ITP Enrollment Packet
- Disclosure and Authorization Form (**Non-Family Members Only**)
- Acknowledgment and Authorization of Background Check (**Non-Family Members Only**)

Please read **ALL** of the enclosed information carefully and return original signed copies to theaddress provided in the enrollment packet.

For any application with a relationship status of “Non-Family Member”, Modivcare will be required to conduct a criminal background check and motor vehicle driving record check on the participant’s behalf.

Best Regards,

Heather Williams
Sr. Director, Transportation
Modivcare

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Individual Transportation Participant (ITP) Enrollment Checklist

Use this checklist to make sure all the items needed to sign up to be an ITP are completedand submitted. No trips will be authorized until all documents have been approved.

For help filling out these forms, call Modivcare Contact Center at **877-718-4201 select option 2 for Superior Health Plan.**

- ☐ Original completed ITP Information Page
  (*Please fill out everything, and mark N/A where if a question does not apply.)*
- ☐ Original completed Client/ITP Information Page
- ☐ Original completed Terms and Conditions Participation signature
- ☐ A copy of your current and valid Texas Driver's License
- ☐ A copy of your current and valid Texas auto insurance card (declarations page or insurance card showing it has minimal requirement by law)
- ☐ A copy of your Social Security card
- ☐ A copy of vehicle Texas registration

Important: The name listed on your driver's license and Social Security card must be the same.

All forms must be mailed to Modivcare

ATTN: Modivcare
2851 Joe DiMaggio Blvd Bldg 8 unit-15
Round Rock, Texas 78665
Note: *Please retain a copy for your records.*

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ITP Information Page

The purpose of the form is to obtain data to sign up to be an ITP. You must fill out this entireform and sign it. Please use blue or black ink. Original signature only; copies or stamped signature will not be accepted.

ITP Status: Self/Other:	**Telephone Number:(if we need to contact you)**
☐ Self ☐ Other	( )

Must match Driver's License **Last Name :**	**First Name:**	**Middle Initial:**

Social Security Number:(*Please attach copy of card)*	**Date of Birth:**

Driver's License Number: *(Please attach a copy of driver's license).*	**License Issue Date:** ***MM/DD/YYYY***	**License Expiration Date:** ***MM/DD/YYYY***

Physical Address: *This is where you live. (You must give a street address. PO boxes will not be accepted.) Number, Street, City, State, and Zip Code*

Mailing address:
Number, Street, City, State, and Zip Code.

***Important**: the name on your driver's license, social security card must be the same.*

Vehicle & Insurance Information

Vehicle Identification Number (VIN): *Please provide VIN of vehicle used to transport.*	**License Tag:**

Auto Insurance Policy: *Please attach a copy of insurer insurance card. The vehicle used to transport the client must be listed oninsurance policy.*	**Policy Issue Date:** ***MM/DD/YYYY***	**Policy Expiration Date:** ***MM/DD/YYYY***

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Client/ITP Information Page

If you are driving yourself or family members only, fill out **Section 1, leave Section 2 blank**.
If you are driving a person other than yourself or a family member, fill out **Section 1 and Section 2.**
*Please list all clients for which driver will be requesting reimbursement

Section 1

Client Name: *(the person you will be driving)*	**Medicaid ID #:**	**Client DOB:** ***MM/DD/YYYY***	**Relationship to ITP:**
			☐ Family Member ☐ Non-Family Member ☐ Self

Section 2 (*Facts about the ITP*)

Are you currently charged with or have you even been convicted of a crime (excluding Class C misdemeanor traffic citations)?

☐Yes ☐No

"Convicted" means that:

(a) A judgment of conviction has been entered against an individual by a Federal, State or local court, regardless of whether:
  (1) There is a post-trial motion or an appeal pending; or
  (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual;

(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual, or

(d) An individual has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

*If **Yes**, fully explain the details including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*

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Terms and Condition of Participation

1. *Before an ITP drives a client, the client must get approval for the ride from Modivcare. The client must call 1-877-718-4201 to get this approval prior to the trip otherwise the ITP will not get paid. All clients must be listed on the Client/ITP Page.*
2. *The client must have the doctor sign the ITP Service Record (Claim Form) andthe ITP must sign the ITP Service Record (Claim Form).*
3. *The mileage reimbursement (payment) amount is based on a mileage calculation computed by Modivcare using a nationally recognized system of theshortest distance of the trip and not on the number of clients who are given a ride. The ITP will be paid based on the determined mileage at the vehicle mile rate set by the Texas Legislature for state employees that is in effect at the time of the ride.*
4. *All payments to an ITP will be reported to the Internal Revenue Service (IRS).*
5. *The ITP must maintain a current and valid Texas driver's license, vehicle insurance, and Texas vehicle registration during each ride.*
6. *The claim form must be submitted within 95 days from the date of the ride.*

Attestation:

I attest that I have read the terms and conditions of participation as an Individual Transportation Participant (ITP) and that the information provided in this application is true and correct. I understand that I must comply with the terms and conditions of participation and maintain documentation to support any mileage reimbursement claim and that HHSC or Modivcare reserves the right to request and validate documentation being relied upon to support mileage reimbursement claims.

_____ _____

Signature of Individual Transportation Participant Date

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ITP Service Record (Claim Form)

Client Name:	Client Telephone:	Client Medicaid:
	( )	
ITP Name (Must match Driver's License)	**ITP Telephone:**	**ITP MTI Number:**
	( )	

Trip #1

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	

Trip #2

From:	To:	Miles:	Amount:
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**	**Total Amount:**
Health Care Provider NPI:	**Health Care Provider Telephone:**	**Health Care Provider Name:**	
	( )		
I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.	**Signature & Title of Health-care Provider:**	**Date Signed:**	

ITP Drivers: *Please note that the allowable mileage that may be claimed for reimbursement is preprinted on the form.*

AFFIDAVIT: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim is from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws. I hereby certify that this claim contains no willful misrepresentation or falsification and that the information I have given is true and correct to the best of my knowledge and belief. **I attest that I have complied with all of the provisions of the Individual Transportation Participant Agreement when providing the transportation services for which I am seeking reimbursement.**

Signature of Individual Transportation Participant (ITP) Date

Claim form must be mailed to Modivcare

ATTN: Claims 798 Park Ave NW 4th Floor Norton, VA 24273

Emailed to: Virginia.billingoperations@modivcare.com

Faxed to: 866-528-0462

Note: *Please retain a copy for your records*