MEMBER NAME (ITP DRIVER NAME)
ADDRESS
CITY, STATE ZIP

Dear Individual Transportation Participant:

The enclosed is the **NEW** Individual Transportation Participant (ITP) Agreement. Please answer all questions, sign, date, and return the ITP Agreement and the required documentsby mail, fax or email to the following:

Fax Number:
713-747-9453

Mailing address:
A2C ITP Claims
9555 W Sam Houston Pkwy S, Suite 500
Houston, TX 77099

Email:
claimsdept@gmr.net

Please send in the following completed forms **as soon as possible to our office** after youhave received them:

- The Individual Transportation Participant Agreement (this letter)
- The ITP Application Packet (all pages)
- All required documents listed in this Agreement

Additional **IMPORTANT** Information You Need to Know:

- We are available to assist you by phone from 8:00am to 5:00pm, Monday to Friday, except federal holidays.
- All trips must be scheduled in advance by calling Access2Care at one of the assigned numbers listed below. *Dialysis and other recurring appointments can bescheduled for up to three months at a time.

Health Plan	Toll-Free Number
Aetna STAR and STAR Kids	866-411-8920
Amerigroup MMP	844-869-2767
Amerigroup STAR	833-721-8184
Amerigroup STAR Kids	844-864-2443
Amerigroup STAR+PLUS	844-867-2837
Community Health Choice STAR	844-572-8194
Cook Children’s STAR and STAR Kids	844-572-8195

Health Plan	Toll-Free Number
Dell Children's STAR	844-867-2742
El Paso Health STAR	844-572-8196
FirstCare Health Plan STAR	833-779-3105
Molina Healthcare of Texas MPP	866-462-4856
Molina Healthcare of Texas STAR and STAR+PLUS	866-462-4857
Parkland Community	833-933-8444
Scott & White STAR	877-447-3101

- Access2Care must have ALL required documents on file before we can processpayment requests or schedule any future trips.
- You will only be reimbursed for trips that are scheduled in advance and traveling toMedicaid-covered services. Be sure to obtain a confirmation number from Access2Care when scheduling trips.
- ITP Trip Log(s) must be signed/stamped and dated by the healthcare provider or their authorized representative (example – nurse, receptionist, assistant) for each trip.
- Mail or fax completed ITP Trip Log(s) to us upon the completion of your trip.
- You will be reimbursed mileage from the member's residence to the medical appointment and back to the member's residence.
- It may take up to 4 weeks for reimbursement after we have received and processedyour completed Trip Log.

For questions regarding the packet, please contact Access2Care at 844-688-7462.

Individual Transportation Participant Agreement

____ ("You") and Access2Care (A2C) agreeas follows:

As the approved Individual Transportation Participant (ITP), you agree to the following:

Effective January 1, 2021, A2C shall compensate you at the rate prescribed by HHSC for transportation services provided to an eligible Medicaid member to and/or from their appointmentfor Medicaid-covered services.

1. To receive mileage reimbursement, you need to provide A2C with the following:

    a. Photocopy of your current valid driver's license. A motor vehicle operator without a valid driver's license may not provide transportation services underthe ITP program.
    b. Proof of your current vehicle insurance card which shows the Policy Number, dates covered and the minimum liability insurance required by Texas Law forthe vehicle used to transport the member.
    c. Photocopy of your Social Security Card.
    d. Proof of valid vehicle registration and a VIR (Vehicle Inspection Report)
    e. The original Individual Transportation Participant Agreement signed anddated by you.
    f. **If you are transporting anyone other than yourself or a family memberthe following requirements apply:**
        i. **A copy of a valid driving record that is maintained by the Texas Department of Public Safety will be obtained by A2C at no cost toyou and a copy will be included in the file.**
        ii. **A copy of a public criminal record of the motor vehicle operatorthat is maintained by the Texas Department of Public Safety willbe conducted by A2C at no cost and a copy will be included in the file.**

http://www.dps.tx.gov

2. Before an ITP trip takes place, the trip must be scheduled with Access2Care.
3. A2C will verify the documents that the driver has provided.
4. The healthcare provider or authorized representative must stamp/sign and date the Trip Log during the visit. The drivermust also sign the Trip Log where indicated. The driver will not get paid without asigned and completed Trip Log.
5. The ITP must mail the completed Trip Log to A2C after the member's authorized ride, but no later than 95 days from the date of the ride. **Any claims received byA2C more than 95 days after the date of the ride will be denied.**

6. A2C may place a driver's payments on hold until the driver has resolved all his/her outstanding debts with the State of Texas.
7. The driver must not give the name of any member to anyone other than HHSC, the member's assigned Managed Care Organization, or A2C. This applies to anyone thedriver has transported in the past. Information about people covered by Medicaid must be kept private and is protected by both state and federal law.
8. The driver can be the Medicaid member, a family member, neighbor, or other personwho has been approved by A2C to transport someone to their Medicaid-covered visit.
9. The amount the driver gets reimbursed is based on the mileage of the trip.
10. A2C uses Geocoding to calculate the trip distance. The driver will be reimbursed permile at the vehicle mileage rate set for state employees by the Texas Legislature effective on the requested trip date.
11. If you are self-declared as "other", you must **not have more than 10 eligible clients**on your panel. Individuals that transport more than 10 ITP eligible members must be classified as a MTO subcontractor and adhere to appropriate enrollment requirements.
12. Providing transportation to Texas Medicaid enrolled members is a voluntary service and the ITP driver is responsible for ensuring safe passage in compliance with State Law. This includes, but is not limited to, proper usage of seat belts, booster seats, and child seats.
13. The ITP driver assumes all responsibility for any and all risk of accident, automotive damage or bodily injury that occur providing services and releases, waives and discharges all claims by reason of or arising in connection with providing transportation services against the Managed Care Organization, Access2Care, and its officers, directors, employees and agents.

I,____, hereby declare that I have read the above terms and conditions of this Individual Transportation Participant Agreement, and I understand that I must comply with all the terms and conditions. In addition, I attest that the vehicle I use to transport Medicaid members to appointments has a current vehicle registrationand Texas state safety inspection.

Signature: ____

Print Name: ____

Date: ____

Please keep a copy of this Agreement and send the original signed Agreement with all required documents to:

A2C ITP Claims
9555 W Sam Houston Pkwy S, Suite 500
Houston, TX 77099
Email: claimsdept@gmr.netFax:
713-747-9453

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Individual Transportation Participant (ITP) Application Checklist

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

For help filling out these forms, call A2C toll free at 844-688-7462

- ☐ A copy of your completed ITP Information Page (*Please fill out everything, and mark N/A if a question does not apply.)*
- ☐ A copy of your completed Client/ITP Information Page
- ☐ A copy of your current and valid Driver's License
- ☐ A copy of your current and valid auto insurance card
- ☐ A copy of your Social Security card
  Important: The name listed on your driver's license and Social Security card must be the same.
- ☐ A copy of your vehicle registration and inspection report

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All forms must be mailed, emailed or faxed to:A2C ITP

Claims
9555 W Sam Houston Pkwy S, Suite 500
Houston, TX 77099
Email: claimsdept@gmr.netFax:
713-747-9453

Note: *Please retain a copy for your records.*

ITP Information Page **The purpose of the form is to obtain data to sign up to be an ITP. You must fill out thisentire form 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 on insurance policy.*	**Policy Issue Date:** ***MM/DD/YYYY***	**Policy Expiration Date:** ***MM/DD/YYYY***

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**.

Section 1

Client Name: *(the person you will be driving)*	**Medicaid ID #:**	**Health Plan Name**	**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 ofa crime (excluding Class C misdemeanor traffic citations)?

“Convicted” means that:

- **(a) A judgment of conviction has been entered against an individual by a Federal, State or local court, regardless ofwhether:**
  - **(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 otherwiseremoved;**
- **(b) A Federal, State or local court has made a finding of guiltagainst an individual;**
- **(c) A Federal, State or local court has accepted a plea of guiltyor 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 beenwithheld.**

☐ Yes ☐ No

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

Terms and Condition of Participation

Terms and Conditions of Participation

- The trip must be scheduled with Access2Care before the trip date.
- The Trip Log must be signed/stamped and dated by the Medicaid service provider or their authorized representative (example – nurse, receptionist, assistant).
- The Trip Log must be signed and dated by ITP.
- The mileage reimbursement (payment) amount is based on mileage calculation of the shortest trip distance determined by a nationally recognized geocoding system. Payment is not based on the number of members transported. The driver will be reimbursed per mile at the vehicle mileage rate set for state employees by the Texas Legislature effective on the requested trip date.
- The ITP must maintain the following for each trip:
    1) Current and valid driver's license
    2) Current vehicle insurance
    3) Current vehicle inspection
    4) Current vehicle registration
- Trip Logs must be completed, signed, and submitted to Access2Care 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 claimand that your health plan reserves the right to request and validate documentation being relied upon to support mileage reimbursement claims.

Signature of Individual Transportation Participant (ITP)	Date

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ITP Service Record (Trip Log/Claim Reimbursement Form 3103)

Client Name:	**Client Telephone:** ( )	**Client Medicaid:**
ITP Name:	**ITP Telephone:** ( )	**ITP Driver's License #**

Trip #1			
From:	**To:**	**Miles:**	**Amount:**
From:	**To:**	**Miles:**	**Amount:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**	
Healthcare Provider NPI:	**Healthcare Provider Telephone:** ( )	**Healthcare Provider Name:**	
I certify that this patient was seen for a Medicaid-covered healthcare service.	**Signature & Title of Healthcare Service Provider or Authorized Representative:**	**Date Signed:**	

Trip #2		
From:	**To:**	**Miles:**
From:	**To:**	**Miles:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**
Healthcare Provider NPI:	**Healthcare Provider Telephone:** ( )	**Healthcare Provider Name:**
I certify that this patient was seen for a Medicaid-covered healthcare service.	**Signature & Title of Healthcare Service Provider or Authorized Representative:**	**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

All forms must be sent toA2C ATTN:
ITP CLAIMS
9555 W Sam Houston Pkwy S, Suite 500
Houston, Texas 77099
Fax: 713-747-9453
Email: claimsdept@gmr.net
Note: *Please retain a copy for your records*

ITP Acknowledgement Form

ITP Driver/Owner: ____

I____acknowledge, the name listed above as my ITP choice. The person will be responsible for transporting me to and from my approved Medicaid appointments. I understand that the person has to enroll to receive reimbursement for trips performed.

Client Signature:____Date: __________________________

ITP Service Record (Trip Log/Claim Reimbursement Form 3103)

Client Name:	**Client Telephone:** ( )	**Client Medicaid:**
ITP Name:	**ITP Telephone:** ( )	**ITP Driver's License #**

Trip #1		
From:	**To:**	**Miles:**
From:	**To:**	**Miles:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**
Healthcare Provider NPI:	**Healthcare Provider Telephone:** ( )	**Healthcare Provider Name:**
I certify that this patient was seen for a Medicaid-covered healthcare service.	**Signature & Title of Healthcare Service Provider or Authorized Representative:** ☐	**Date Signed:**

Trip #2		
From:	**To:**	**Miles:**
From:	**To:**	**Miles:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**
Healthcare Provider NPI:	**Healthcare Provider Telephone:** ( )	**Healthcare Provider Name:**
I certify that this patient was seen for a Medicaid-covered healthcare service.	**Signature & Title of Healthcare Service Provider or Authorized Representative:** ☐	**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 ______________

All forms must be sent toA2C ATTN:
ITP CLAIMS
9555 W Sam Houston Pkwy S, Suite 500
Houston, Texas 77099
Fax: 713-747-9453
Email: claimsdept@gmr.net
Note: *Please retain a copy for your records*

EXAMPLE - ITP Service Record (Trip Log/Claim Reimbursement Form 3103)

Client Name: JOHN DOE	**Client Telephone:** (123) 123-1234	**Client Medicaid: 123456789**
ITP Name: JOHN DOE	**ITP Telephone:** (123) 123-1234	**ITP Driver's License # 01234567**

Trip #1		
From: 123 MAIN ST CITY, STATE, ZIP CODE	**To: 214 OAK ST CITY, STATE,ZIP CODE**	**Miles:**
From: 214 OAK ST CITY, STATE, ZIP CODE	**To:123 MAIN ST CITY,STATE,ZIP CODE**	**Miles:**
Authorization Number: **12345678**	**Appointment Date/Time:** **1/27/2019 3:00 PM**	**Total Miles:**
Healthcare Provider NPI: 1234356789	**Healthcare Provider Telephone:** (123) 123-1234	**Healthcare Provider Name:** **DR. DONALD GLOVER**
I certify that this patient was seen for a Medicaid-covered healthcare service.	**Signature & Title of Healthcare Service Provider or Authorized Representative:** **SIGNATURE, TITLE**	**Date Signed:** **1/27/2021**
Trip #2		
From:	**To:**	**Miles:**
From:	**To:**	**Miles:**
Authorization Number:	**Appointment Date/Time:**	**Total Miles:**
Healthcare Provider NPI:	**Healthcare Provider Telephone:** ( )	**Healthcare Provider Name:**
I certify that this patient was seen for a Medicaid-covered healthcare service.	**Signature & Title of Healthcare Service Provider or Authorized Representative:**	**Date Signed:**

Example

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.**

EXAMPLE	EXAMPLE
Signature of Individual Transportation Participant (ITP)	Date

All forms must be sent to
A2C ATTN: ITP CLAIMS
9555 W Sam Houston Pkwy S, Suite 500
Houston, Texas 77099
Fax: 713-747-9453
Email: claimsdept@gmr.net
Note: *Please retain a copy for your records*

EXAMPLE OF TRIP WITH ADDITIONAL STOP

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ITP Service Record (Trip Log/Claim Reimbursement Form 3103)

Client Name: JOHN DOE	Client Telephone: (123) 123-1234	Client Medicaid: 123456789
ITP Name: JOHN DOE	ITP Telephone: (123) 123-1234	ITP Driver's License # 01234567

Trip #1			
From: 123 MAIN ST CITY, STATE, ZIP CODE T-HOME	To: 214 OAK ST CITY, STATE,ZIP CODE 1ST STOP	Miles:	Amount:
From: 214 OAK ST CITY, STATE, ZIP CODE I- 1ST STOP	To:123 MAIN ST CITY,STATE,ZIP CODE 2ND STOP	Miles:	Amount:
Authorization Number: 12345678	Appointment Date/Time: 1/27/2019 3:00 PM	Total Miles:	Total Amount:
Health Care Provider NPI: 1234356789	Health Care Provider Telephone: (123) 123-1234	Health Care Provider Name: DR. DONALD GLOVER	
I certify that this patient was seen for a Medicaid/CSHCN covered health-care service.	Signature & Title of Health-care Provider: ➡ DOCTOR SIGNATURE, TITLE	Date Signed: 1/27/2021	

Trip #2			
From: R- 2ND STOP	To: HOME	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: ➡ DOCTOR SIGNATURE, TITLE	Date Signed: DATE	

Example

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.**

SIGN HERE — Signature of Individual Transportation Participant (ITP)

DATE — Date

All forms must be sent to
A2C ATTN: ITP CLAIMS
9555 W Sam Houston Pkwy S, Suite 500
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