

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 documents by 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:

a2cclaimsdept@mtm-inc.net

Please send in the following completed forms **as soon as possible to our office** after you have 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 be scheduled for up to three months at a time.

| Health Plan | Toll-Free Number |
|---|-------------------------|
| Aetna TX STAR and STAR Kids | 866-411-8920 |
| Wellpoint TX STAR | 833-721-8184 |
| Wellpoint TX STAR Kids | 844-864-2443 |
| Wellpoint TX STAR+PLUS | 844-867-2837 |
| Community Health Choice STAR | 844-572-8194 |
| Community Health Choice STAR+PLUS | 833-502-0131 |
| Cook Children's STAR and STAR Kids | 844-572-8195 |
| Dell Children's STAR, CHIP and CHIP Perinatal | 844-867-2742 |
| El Paso Health STAR | 844-572-8196 |
| El Paso Health STAR+PLUS | 855-584-3530 |
| FirstCare Health Plan STAR | 833-779-3105 |
| Molina Healthcare of Texas MMP | 866-462-4856 |

| | |
|---|--------------|
| Molina Healthcare of Texas STAR and STAR+PLUS | 866-462-4857 |
| Parkland Community | 833-931-3844 |
| Scott & White STAR | 877-447-3101 |

- Access2Care must have ALL required documents on file before we can process payment requests or schedule any future trips.
- You will only be reimbursed for trips that are scheduled in advance and traveling to Medicaid 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 processed your completed Trip Log.

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

Individual Transportation Participant Agreement

_____ (“You”) and Access2Care (A2C)
agree as 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 appointment for 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 under the 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 for the vehicle used to transport the member.
 - c. Photocopy of your Social Security Card.
 - d. Proof of valid vehicle registration
 - e. The original Individual Transportation Participant Agreement signed and dated by you.
 - f. **If you are transporting anyone other than yourself or a family member the 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 to you and a copy will be included in the file.**
 - ii. **A copy of a public criminal record of the motor vehicle operator that is maintained by the Texas Department of Public Safety will be 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 driver must also sign the Trip Log

where indicated. The driver will not get paid without a signed 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 by A2C 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 the driver 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 person who 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 per mile 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 registration and 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: a2claimsdept@mtm-inc.net

Fax: 713-747-9453

ITP Information Page

The purpose of the form is to obtain data to sign up to be an ITP. You must fill out this entire 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) | |
| <input type="checkbox"/> Self <input type="checkbox"/> Other | | () | |
| <i>Must match Driver's License</i> | | | |
| Last Name: | | First Name: | Middle Initial: |
| | | | |
| Social Security Number:(Please attach copy of card) | | Date of Birth: | |
| | | | |
| Driver's License Number: <i>(Please attach a copy of driver's license).</i> | | License Issue Date: <i>MM/DD/YYYY</i> | License Expiration Date: <i>MM/DD/YYYY</i> |
| | | | |
| Physical Address: <i>This is where you live. (You must give a street address. PO boxes will not be accepted.) Number, Street, City, State, and Zip Code</i> | | | |
| | | | |
| Mailing address: <i>Number, Street, City, State, and Zip Code.</i> | | | |
| | | | |

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

| | | |
|--|--|---|
| Vehicle & Insurance Information | | |
| Vehicle Identification Number (VIN): <i>Please provide VIN of vehicle used to transport.</i> | License Tag: | |
| | | |
| Auto Insurance Policy: <i>Please attach a copy of insurer insurance card. The vehicle used to transport the client must be listed on insurance policy.</i> | Policy Issue Date: <i>MM/DD/YYYY</i> | Policy Expiration Date: <i>MM/DD/YYYY</i> |
| | | |

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: <i>(the person you will be driving)</i> | Medicaid ID #: | Health Plan Name | Client DOB: <i>MM/DD/YYYY</i> | Relationship to ITP: |
|---|-----------------------|-------------------------|---|---|
| | | | | <input type="checkbox"/> Family Member <input type="checkbox"/> Non-Family Member <input type="checkbox"/> 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)?

“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 Yes No 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)*

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 claim and 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

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 | Date Signed: |
| | <input type="checkbox"/> Provider or Authorized Representative: | |
| 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 | Date Signed: |
| | <input type="checkbox"/> Provider or Authorized Representative: | |

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

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: _____

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

| | | |
|--|---|---|
| Client Name: JOHN DOE | Client Telephone: (555) 555-5555 | Client Medicaid: 123456789 |
| ITP Name: JOHN DOE | ITP Telephone: (555) 555-5555 | ITP Driver's License # 01234567 |
| Trip #1 | | |
| From: 123 MAIN ST NOWHERE, TX 12345 | To: 456 WEST ST NOWHERE, TX 12346 | Miles: 5 |
| From: 456 WEST ST NOWHERE, TX 12346 | To: 123 MAIN ST NOWHERE, TX 12345 | Miles: 5 |
| Authorization Number: 567894123 | Appointment Date/Time: 01/01/2025 1:00PM | Total Miles: 10 |
| Healthcare Provider NPI: 11223344556 | Healthcare Provider Telephone: (123)551-5555 | Healthcare Provider Name: Dr. Jane Bo |
| I certify that this patient was seen for a Medicaid-covered healthcare service. | Signature & Title of Healthcare Service Provider or Authorized Representative: <i>Jane Bo</i> | Date Signed: 01/01/2025 |

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.**

John Doe

01/01/2025

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: a2cclaimsdept@mtm-inc.net
Note: Please retain a copy for your records