SOUTH COUNTRY
HEALTH ALLIANCE

Provider Bulletin/Update

10/21/2020

Update: Transportation Provider Information Verification

South Country Health Alliance (South County) is in the process of gathering current information on all Transportation Providers.

NOTE: THIS WILL BECOME AN ANNUAL PROCESS TO CONFIRM ALL INFORMATION IS UP TO DATE.

Please provide the following information by DECEMBER 1st, 2020:

On the attached Provider information form:

- Complete all organization information.
- Complete the Driver and Employee Roster for anyone who has physical contact with our members & anyone with a 5% or greater ownership stake in the business. Include their Driver's License Number and their completed NetStudy.
- List all counties in Minnesota that you serve and the locations your company dispatches drivers from.
- Complete Vehicle List to include Make, Model, Year, Color, Plate Number, VIN Number and date of last MN DOT inspection for each vehicle.

Please submit copies of the following documents:

- Most current Net studies on all drivers.
- Current Ownership information and percentage (Complete the attached Ownership Disclosure form).
- Most recent MNDOT Special Transportation Services Certificate of Compliance.
- Current Certificate of Liability Insurance.

Please email all of the above information to South Country Health Alliance at **providerinfo@mnscha.org** with a subject line of **"Transportation Information Verification".**

Office use only
PCC#____________

Transportation Provider Information Form

EFFECTIVE January 1, 2021 additional claim information needed

SPECIAL TRANSPORTATION ONLY "STS - Assisted"

Starting 1-1-21 the Driver License number of the person who transports the member will be required on the 837P claim. On Codes T2003, T2005 and A0130 the Loop 2400 under *SV101-7, the description field must include the driver's license number, or the claim will reject/deny. The number must be a valid driver license number with no spaces or dashes.*

Please provide the information about your organization below

General Information

Name of Organization:____

Dba:____

Website: ____

Federal Tax ID #:______________________ **NPI #:** ______________________

UMPI #: If applicable ______________________

Parent Organization (if different from Organization Name):______________________

Primary Location Address:______________________ County: ____________

City:______________________State:____________Zip Code (9 digits):____________

Telephone Number:______________________Ext:____________ Fax: ____________

Email Address: ____

If Correspondence address is different from primary address, please provide below:

Address: ____

City:______________________State:____________Zip Code (9 digits):____________

Telephone Number:______________________ Ext:____________ Fax: ____________

Email Address: ____

Person Responsible for Contracting:

Name:____

Title:______________________ Phone______________________ **Email**______________________

Please check all that apply:

STS Services - Assisted ☐ Ambulatory w/Walker ☐ Wheelchair Assessable Van ☐ Stretcher
ATS Services - Unassisted ☐ Ambulatory (no assistance)
☐ Other Please indicate what other type of transportation ______________________________

Hours of Operation: Office:__________________________ Transit Hours:______________________________

Do you have After Hours Answering / Machine ☐ Yes ☐ No

What services do you provide on weekends and Holidays? ______________________________

(If there are more than 2 additional locations please copy this sheet)

Additional Location Information

Location Name						Correspondence to this address? ☐ Yes ☐ No
Publish location in Directory ☐ Yes ☐ No	If No, why?	Hours of Operation:			Tax Id (if different from above)	
Street Address City State Zip			Phone	Fax	Toll Free	
Billing Address if different City State Zip					NPI or UMPI	
Type of Services provided at this location:						

Additional Location Information

Location Name						Correspondence to this address? ☐ Yes ☐ No
Publish location in Directory ☐ Yes ☐ No	If No, why?	Hours of Operation:			Tax Id (if different from above)	
Street Address City State Zip			Phone	Fax	Toll Free	
Billing Address if different City State Zip					NPI or UMPI	
Type of Services provided at this location:						

CONTACT PERSON INFORMATION

Name:		☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Email Address:
Occupation:	Title:	Phone No:	Fax No:
Any other helpful information:			

NAME OF THE PERSON COMPLETING THIS FORM

Name:	Title:	Date:	Phone No:	Email Address:

Please list first and last names and License numbers of all your drivers and employees who will have contact with our members. Please indicate those that have had a NetStudy done and supply a copy of the study to South Country Health Alliance.

First Name	Last Name	Driver's License #	Net Study	First Name	Last Name	Driver's License #	Net Study

Provide a list of the Counties you provide STS (assisted) services, if you only serve a portion of a county, identify which portion you service within that particular county.

Provide a list of the Counties you provide ATS (unassisted) services, if you only serve a portion of a county, identify which portion you service within that particular county.

Please provide location of your dispatch offices:

Please list all vehicles used for your transportation service, and the last MNDOT Inspection date.

(If you need more spaces please copy this sheet)

Vehicle Year	Make	Model	Color	Plate #	VIN	Last Inspection Date