MAP-572A (Rev. 02/16)

Final approval by OTD management: Reviewed by:_____ Date:_____	COMMONWEALTH OF KENTUCKY Cabinet For Health and Family Services Department For Medicaid Services	To be completed by KY Medicaid: Provider Number: 56_____
To be completed by OTD: Verified Information: *(for Private Auto Providers only)* Signature:_____ Date:_____	**Private Auto Transportation Provider Agreement**	Div. of Program Integrity checks completed by: Signature:_____ Date:_____

Each individual applying for a Kentucky Medicaid transportation provider number must complete a separate form.

_____ _____

(Print your full name) *(Social Security Number)*

The applicant agrees to:

- Transport Medicaid recipients to and/or from medical services and provide referrals for outside the medical service area;
- Obey all applicable federal and state laws and regulations concerning the Kentucky Medicaid Program and the Kentucky Transportation Cabinet *(driver's license, automobile/vehicle registration and insurance requirements)*;
- Not discriminate on the basis in the provision of services due to age, handicap, national origin, race, or sex in the prevision of service;
- Keep all records of all transportation services provided to Medicaid recipients for a minimum of five (5) years *(letters, statements, etc.)* for review purposes;
- Notify the Cabinet For Family and Health Services, Department For Medicaid Services of any name or address change.

I understand there may be civil or criminal penalties if I intentionally defraud the Department For Medicaid Services.

The provider or the Cabinet may terminate this agreement at any time. This constitutes the entire agreement between the Cabinet for Family and Health Services and the provider.

APPLICANT INFORMATION:

Original Signature:_____

Date:_____

Physical Address:_____

_____

Mailing Address:_____

_____

Email Address: _____

Driver's License Number:_____

Residing County:_____

Phone Number:__(_____) _____

(FOR AGENCY USE ONLY)
Department For Medicaid Services

Authorized Signature:_____

Title:_____

Approval Date:_____

(FOR BROKER USE ONLY)

Broker Name:_____

Broker Signature:_____

Approval Date:_____

CLEAR FORM

Please return form to:
KY Medicaid Provider Enrollment, P.O. Box 2110, Frankfort, KY 40602-2110