

SD MEDICAID NON-EMERGENCY MEDICAL TRAVEL (NEMT) PROVIDER AGREEMENT

To Participate in the Medicaid Non-Emergency Medical Travel (NEMT) Program

The SD Medicaid Non-Emergency Medical Travel (NEMT) Provider Agreement is executed by an eligible NEMT provider (hereinafter referred to as 'Provider'), and the State of South Dakota, acting by and through its Department of Social Services, Office of Finance/EBT, hereinafter called Finance/EBT.

As a participating Provider, the Provider agrees to the following:

1. General

- a. Provider is currently a charitable organization as defined in ARSD Chapter 67:16:49:01.
- b. Provider agrees to comply with all Federal and State laws, regulations and rules applicable to Provider's participation in the NEMT program, including program regulations located in ARSD Chapter 67:16:49.

2. Ownership and Control

- a. Provider certifies that Provider, Provider's principals, and/or any person or entity with any "ownership interest," is not currently, and has never been, suspended, debarred, proposed for debarment, declared ineligible, or voluntarily or otherwise excluded from participation in this transaction by any Federal department or agency. Further, the Provider agrees to notify the NEMT program by certified mail within ten (10) days should the Provider or any of its employees, agents, contractors, or any person or entity with any "ownership interest" become debarred, suspended, proposed for debarment, declared ineligible, or voluntarily or otherwise excluded during the term of this Agreement. Provider further certifies by signing this Agreement that Provider, Provider's principals, and/or any person or entity with any "ownership interest," has never been convicted (including any form of suspended sentence or settlement in lieu of conviction for fraud or abuse) of any crime determined to be detrimental to the best interests of the NEMT program.

3. Inspection and Maintenance of Records

- a. Provider agrees to keep complete and accurate fiscal records that fully justify and disclose the extent of the services rendered and billings made under the NEMT program, and agrees to furnish Finance/EBT and/or Medicaid Fraud Control Unit (MFCU) and/or Department of Health (DOH) and/or Department of Human Services (DHS), upon request and allow access to pertinent financial records, such information regarding any payments claimed for providing these services. Access includes, but is not limited to, the examination, inspection, photocopying and/or auditing of any requested financial records. Provider understands that failure to submit or failure to retain adequate documentation for all services billed to the NEMT program may result in recovery of payments for medical transportation services not adequately documented, and may result in the termination or suspension of Provider from participation in the NEMT program, and may result in civil or criminal liability.
- b. Provider agrees to allow Finance/EBT and/or MFCU and/or DOH and/or DHS immediate access to any and all financial records which may be deemed confidential by any regulatory or licensing agency, board or commission.
- c. Provider agrees to keep their enrollment record current and promptly make updates to changes including, but not limited to, Provider's name, locations and address, contact information, payment details or if there is a change of ownership or corporate entity of Provider. Provider further agrees to supply all documentation necessary for the reimbursement of any outstanding travel advances/billings/claims upon termination from the NEMT program.

4. Travel Advance, Billing and Payment

- a. Travel advances submitted must comply with the format specifications defined by the NEMT program. Failure to comply with the format specifications will result in the claim being rejected.
- b. Provider agrees to provide services as required by the recipient and only in the amount required by the recipient without discrimination on the grounds of age, race, color, sex, national origin, physical or mental disability, marital or economic status.
- c. Provider acknowledges that by submitting a travel advance/billing/claim to the NEMT program, Provider certifies that the travel expenses were advanced to the program recipient prior to the submission of the claim to the NEMT program.

- d. Provider agrees to submit travel advance claims in accordance with billing instructions and as required under any and all state regulations.
- e. Provider agrees to submit travel advances/billings/claims that are timely, true, accurate, and complete. Provider acknowledges by Provider's signature on this agreement that Provider understands that payment and satisfaction of each claim will be from Federal and State funds and that any false claims, statements or documents, or concealment of material fact, may be prosecuted under applicable Federal and State law.
- f. Provider agrees to not make or cause to be made a travel advance/billing/claim, knowing the travel advance/billing/claim to be false, in whole or in part, by commission or omission or in any other respect contrary to the provisions of SDCL ch.22-45.
- g. Provider agrees that travel advances/billings/claims for services rendered to NEMT program recipients shall not exceed the established program rates located in ARSD Chapter 67:16:49:05.
- h. Provider agrees that they will not bill the NEMT program for nights the recipient and/or escort is not present in the lodging establishment provided by the provider.
- i. Provider agrees to accept as payment in full the amounts paid in accordance with established reimbursement rates. The Provider understands that any pre-determined amount provided by the NEMT program or submitted by the Provider on a travel advance claim is an estimate based on the information provided and that a reimbursement determination will be made upon completion of the medical trip, receipt of all required forms and documentation and verification of covered services. The Provider understands that submission of a travel advance is not a guarantee of reimbursement.
- j. Provider acknowledges the time limits for submission of NEMT claims as defined in ARSD Chapter 67:16:35:04.
- k. Provider acknowledges that Finance/EBT is the payer of last resort (subject to certain exceptions) and acknowledges its obligation to pursue payment from all other liable parties. Provider further agrees that in the event Provider receives payment from the NEMT program in error or in excess of the amount properly due under the applicable rules and procedures, Provider will promptly notify Finance/EBT and arrange for the return of any excess money so received.
- l. Provider agrees to accept payment from the SD NEMT program via electronic funds transfer.

5. Termination

- a. Provider agrees failure to comply with any portion of this Agreement, addendums to this Agreement, conditions of participation, or requirements and limits of applicable rules and regulations will be good cause for termination of this agreement.
- b. Provider agrees improper submission of travel advances/billings/claims, or actions deemed an abuse of the NEMT program, or actions involving the NEMT program abuse which result in administrative, civil or criminal liability will be good cause for termination of this agreement.
- c. This agreement will be automatically terminated if Provider is convicted (including any form of suspended sentence) of any crime determined to be detrimental to the best interests of the NEMT program.
- d. This agreement will be automatically terminated if Provider is excluded by the Office of Inspector General pursuant to 42 CFR Part 1002.6.
- e. This agreement may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party.

6. Payment Suspension

- a. In the case that the Provider has failed to maintain their enrollment record with accurate information including, but not limited to, payment details, contact information, address, NEMT reserves the right to suspend payment until the Provider has updated their enrollment record.

7. Effective Date

- a. Provider agreement is binding upon enrollment effective date. Provider agreement will be automatically renewed for one year on July 1 if neither party gives notice requesting termination.

TO BE COMPLETED BY PROVIDER

ORGANIZATION INFORMATION

Organization Legal Name _____

Doing Business As (DBA) Name (if applicable) _____

Tax ID Number _____

CONTACT DETAILS

Contact First Name _____

Contact Last Name _____

Contact Phone Number _____

Contact Fax Number _____

Email Address _____

ORGANIZATION ADDRESS

Location Address

Mailing Address

same as location address

Billing Address

same as location address
 same as mailing address

Address Line 1 _____

Address Line 1 _____

Address Line 1 _____

Address Line 2 _____

Address Line 2 _____

Address Line 2 _____

City _____

City _____

City _____

State _____ Zip _____

State _____ Zip _____

State _____ Zip _____

I verify that I have read and agree to the terms and conditions of the NEMT Provider Agreement.

I declare and affirm under the penalties of perjury that this Agreement has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further declare and affirm under the penalties of perjury that any claim to be submitted pursuant to this Agreement will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct.

I understand all NEMT claims will be reimbursed according to established program guidelines and that all NEMT claims must be submitted within 6 months following the month the service was provided. I understand that there are penalties for fraudulently submitting NEMT claims for reimbursement.

I understand that if Provider is a legal entity other than a person, the person signing the provider agreement on behalf of the Provider warrants that he/she has legal authority to bind Provider.

First/Last Name (Please Print): _____

Signature: _____

Date: _____



South Dakota
Department of
Social Services

OFFICE OF THE SECRETARY
EBT/NEMT
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291
PHONE: 1-866-403-1433
FAX: 605-773-8461
WEB: dss.sd.gov

NEMT PROVIDER QUESTIONNAIRE

| Organization Information | |
|--|--|
| Organization Legal Name: | |
| Tax Identification #: | Are you a non-profit organization: Yes or No |
| Address: | |
| City, State, ZIP: | |
| Service Area (list counties served): | |
| | |
| Contact Name/Title: | |
| Telephone: | Fax: |
| Type of services provided (check all that apply) | |
| <input type="checkbox"/> Cash assistance | <input type="checkbox"/> Provide lodging assistance (direct bill facilities) |
| <input type="checkbox"/> Transport to appointment | <input type="checkbox"/> Other (specify) |
| Description of who services are provided to | |
| Transportation services are provided to: (check all that apply) | |
| <input type="checkbox"/> Limited population group (specify) | |
| <input type="checkbox"/> Entire community | |
| Description of how services are provided | |
| <input type="checkbox"/> In-city only | |
| <input type="checkbox"/> City to city | |
| Do you transport out of state? Yes or No (Specify states) | |
| Type of vehicle: (check all that apply and specify seat capacity) | |
| <input type="checkbox"/> Car or SUV; seat capacity _____ | <input type="checkbox"/> Small bus; seat capacity _____ |
| <input type="checkbox"/> Minivan; seat capacity _____ | <input type="checkbox"/> Large bus; seat capacity _____ |
| Log or billing documents (Yes or No) Please provide a description of how families or individuals are logged by departure date, time, destination, and return time. (Attach a sample) | |
| Schedule: (check all that apply) | |
| <input type="checkbox"/> By appointment | |
| <input type="checkbox"/> Daily (departure/return time) | |
| <input type="checkbox"/> Other (specify): | |

By signing this form, I am certifying that all information is true and correct. I understand all NEMT claims will be reimbursed according to established program guidelines and that there are penalties for fraudulently submitting NEMT claims for reimbursement.

Signature and Title

Date

FOR OFFICE USE ONLY

Type of Provider _____

NEMT Provider # _____

**MAIL SIGNED NEMT PROVIDER AGREEMENT, NEMT
PROVIDER QUESTIONNAIRE AND ANY OTHER
APPLICABLE DOCUMENTATION TO:**

DEPARTMENT OF SOCIAL SERVICES
EBT/NEMT
700 GOVERNOR'S DRIVE
PIERRE, SD 57501-2291

PHONE: 1-866-403-1433
FAX: 1-605-773-8461
EMAIL: DSS.EBTSTATEOFFICE@STATE.SD.US