

Annual Ambulette Survey for 2009

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Providers of Ambulette services are required to submit vehicle information on an annual basis in accordance with Title 18 NYCRR (New York Code, Rules and Regulations) 502.6(b):

Each provider of ambulette services must, during the month of January of each year, disclose to the department in writing, information concerning those vehicles currently owned or leased by the provider.

The information to be disclosed must include at a minimum the name and address of the provider, each vehicle's license number and Department of Transportation identification number and a statement regarding whether the vehicle is owned or leased.

A provider of ambulette services that fails to disclose this information may have its participation in the medical assistance program terminated.

Failure to comply may result in the termination of enrollment as a Medicaid provider.

The form on the following page **must** be returned by **February 17, 2009** to:

*New York State Office of the Medicaid Inspector General
Investigations & Enforcement
Attn: 2009 Ambulette Survey
800 North Pearl St, Lower Level
Albany, NY 12204*

Certified/Return Receipt mail is suggested. A copy of the form and proof of mailing should be retained for your records. In the event of non-receipt of the form by the Office of the Medicaid Inspector General, this proof will be used to validate compliance.

The Annual Ambulette Survey form is available on the OMIG webpage under "Provider Compliance" –

www.omig@state.ny.usdata/images/stories//annual_ambulette_survey_for_2009.pdf

NEW YORK STATE MEDICAID INSPECTOR GENERAL
Bureau of Investigations & Enforcement
AMBULETTE QUESTIONNAIRE

PROVIDER NAME: _____

ADDRESS: _____

NEW YORK MEDICAID PROVIDER # _____

IF ADDITIONAL SPACE IS NEEDED, PROVIDE INFORMATION BY ATTACHMENT

GENERAL INFORMATION

1. Business phone number: (____) _____ Fax Number: (____) _____

2. Business website: _____

3. List any change in the business name and address if different from above:

4. Identify the following personnel (**PLEASE TYPE OR PRINT**):

OWNER 1: _____

OWNER 2: _____

PRESIDENT: _____

VICE PRESIDENT: _____

SECRETARY: _____

TREASURER: _____

CHIEF EXECUTIVE OFFICER (CEO): _____

5. Does the business have more than one New York Medicaid provider number(s) or National Practitioner Identification (NPI) number?

Yes No

If yes, list the additional New York Medicaid provider/NPI number(s):

6. Do you, or any other owners/officers of the business, own or have an equity interest in other businesses that provide transportation services, whether a Medicaid provider or not?

Yes No

Please list these businesses by name and New York Medicaid provider/NPI number.

7. Does the business operate from any location(s) other than the address listed above?

Yes No

If yes, identify the location(s):

8. Does the business have a Medicaid provider agreement in another state(s)?

Yes No

If yes, identify the state(s) and provider's name(s) and number(s):

9. Approximately what percent of the business' customer population is Medicaid eligible?
_____ %

10. On average, how many Medicaid consumers does the business service per month? _____

11. Does the business have a service contract with a physician, group or nursing home, clinic, or hospital for the purpose of transporting Medicaid consumers?

Yes No

If yes, attach a list of those physicians, group or nursing homes, clinics, or hospitals with which the business has service contracts.

12. Does **ANY INDIVIDUAL** employed (full or part time) by the company have (or has ever had) any other Medicaid provider number(s), whether currently active or inactive?

Yes No

If yes, identify the provider name(s) and number(s):

PROVIDER NAME: _____

PROVIDER NUMBER: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____

PROVIDER NAME: _____

PROVIDER NUMBER: _____

13. Does the business have a contract with any Medicaid managed care programs?

Yes No

If yes, identify the names of the programs and the length of the contract:

RECORD KEEPING

1. List all transport records that are used any business day for the purpose of logging in and tracking the transports:

2. Who is responsible for filing and maintaining the transport records? List name(s) and titles:

3. **Identify** below (or attach) a list detailing any/all abbreviations or coding which are used in the records:

4. Where are your business records and supporting documentation for Medicaid claims stored/maintained?

5. Are you keeping all records and documents necessary to substantiate transportation services for which Medicaid reimbursement is sought for at least six (6) years, as required by NYCRR 517.3 (b)

Yes No

VEHICLES

1. Indicate the total number of vehicles currently in operation:

Ambulette: _____

2. Are the transport vehicles housed at or dispatched from another location(s)?

Yes No

If yes, identify the location(s):

MEDICAID POLICY UPDATES

1. Does the business have internet access to Medicaid policy updates via the eMedNY webpage <http://www.emedny.org/ProviderManuals/Transportation/index.html>

Yes No

2. Per the requirements of the provider manual for transportation are you familiar with all the requirements set forth in the manual?
<http://www.emedny.org/ProviderManuals/Transportation/index.html>

Yes No

If no, please explain:

3. Are you aware that in order for an ambulette transport to be covered by Medicaid, the individual being transported must actually be rendered personal assistance as defined by the manual? <http://www.emedny.org/ProviderManuals/Transportation/index.html>

Yes No

If yes, when did you become aware of this requirement? _____

If no, please explain: _____

4. Are you aware that in order for an ambulette transport to be covered by Medicaid, the individual being transported must be transported to or from a Medicaid covered service?

Yes No

If yes, when did you become aware of this requirement? _____

If no, please explain: _____

5. Are you aware that in order for an ambulette transport to be covered by Medicaid, the individual being transported must be transported in an ambulette, licensed and approved as such by the New York State Department of Transportation/New York City Taxi and Limousine Commission (Where Applicable)?

Yes No

If yes, when did you become aware of this requirement? _____

If no, please explain: _____

6. Are you aware that in order for an ambulette transport to be covered by Medicaid, you must have on file a Prior Approval signed by an ordering Practitioner covered under 18 NYCRR 505.10(c)(2), for the individual being transported?

Yes No

If yes, when did you become aware of this requirement? _____

If no, please explain: _____

7. Are you aware that you are not permitted to seek Medicaid reimbursement for transportation services provided by another entity?

Yes No

If yes, when did you become aware of this requirement? _____

If no, please explain: _____

8. Are you aware that the use and services of any vehicles and/or drivers leased from another transportation company must be leased from a transportation company that is enrolled as a provider in the Medicaid program?

Yes No

If yes, when did you become aware of this requirement? _____

If no, please explain: _____

