

Non-Emergency Medical Transportation Provider Questionnaire

Provider Name: _____ Provider#/NPI _____

Contact Person: _____ Telephone # _____

Physical Address: _____ City: _____ State: _____

E-Mail Address: _____

1. Are you interested in providing non-emergency medical transportation via Public Utility Licensed (**non-metered**) taxi service, van services, or wheelchair vans for Medicaid recipients?

2. How many service vehicles does your company currently have? **taxi** _____ **vans** _____ **wheelchair** _____

3. Is your service area limited? If yes, please explain. _____

4. How many people would you anticipate being able to transport in **taxi** _____ **vans** _____ **wheelchair** _____ each day?

5. What are your days and hours of operation for non-emergency medical transportation?

6. How many people do you currently transport that you think might benefit from this service?

Provider Signature: _____

Date: _____

Title: _____