PART II

POLICIES AND PROCEDURES
For
EXCEPTIONAL TRANSPORTATION SERVICES (ETS)



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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2022 ETS POLICY REVISIONS RECORD

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
01/01/2022	Not Applicable	No updates this quarter		
04/01/2022	Not Applicable	No updates this quarter		

PREFACE

This manual contains basic information concerning the Exceptional Transportation Services (ETS) Program and is intended for use by all participating providers and in conjunction with the Part I Policies and Procedures Manual for *Medicaid and PeachCare for Kids*. Part I of any DCH manual outlines the Statement of Participation for participating providers. Part II of any DCH manual is program specific and outlines the policies and procedures for that program as well as the terms and conditions for receipt of reimbursement.

We urge you and your office staff to familiarize yourself with the contents of Part I and Part II of the manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning program policies, coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

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Amendments to this manual will be necessary from time to time due to changes in federal and state laws and Department of Community Health (DCH or the Department), Division of Medical Assistance (Division) policy. Manuals are updated and posted quarterly on the Gainwell Technologies (Gainwell) web portal at www.mmis.georgia.gov. Manuals will include any changes or amendments, if applicable, when such amendments are made. These postings shall constitute formal notification to providers of any changes or amendments. The amended or changed provisions will be effective on the date of the notice on the manual or as specified by the notice itself. All providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your interest and participation in Georgia's Medicaid/PeachCare for Kids program and the Exceptional Transportation Services program. Your service is greatly appreciated.

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I. GENERAL INFORMATION

Background

The Georgia Medical Assistance Program (Medicaid) became effective in October 1967, under the provisions of Title XIX of the 1965 amendments to the Social Security Act (42 USC 1396 *et seq.)*. On July 1, 1977, the Georgia Department of Medical Assistance (DMA) was created to administer the Medicaid program (GA Laws 1977, p. 384). On July 1, 1999, the Department of Community Health (DCH) was created to administer health care programs in Georgia, including Medicaid. DMA then became the Division of Medical Assistance within DCH (GA Laws 1999).

DCH is the single State agency charged with the responsibility of administering the Medicaid program. DCH is responsible for assuring that needy Georgians can request and receive Medicaid services through an eligibility process and that providers of these services are reimbursed. DCH administers the Medicaid program through several contracts, in addition to the direct employment of departmental staff. It is divided into multiple divisions and offices responsible for administering Medicaid services and other health care programs in Georgia.

DCH partners with the Department of Human Services' (formerly known as the Department of Human Resources) Division of Family and Children Services (DFCS) to arrange, coordinate and
Rev 4/20 provide Exceptional Transportation Services (ETS) for eligible Medicaid members. ETS provides out-of-state transportation and other travel related expenses and certain services in-state services outlined in Appendix B of this manual. All services provided under ETS require prior authorization from the DCH Medical Management and Utilization Review Services (MMURS) vendor, Alliant Health Solutions (AHS), formerly known as Georgia Medical Care Foundation (GMCF).

ETS provides non-emergency medical transportation and operates separately from the DCH Non-Emergency Medical Transportation (NEMT) program.

Definition of Service

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Exceptional Transportation Services (ETS) is defined as non-emergency medical transportation that requires traveling out of state for medically necessary health care treatment not normally provided through in-state healthcare providers but is necessary under extraordinary medical circumstances. Transportation under this program is limited to out-of-state travel and includes air and ground travel. ETS only covers meals and lodging needs in-state for member's requiring medical treatment and have to travel more than fifty (50) miles from their place of residence, community or vicinity. Eligible members must have no other means of transportation available.

Georgia Medicaid defines the term *out-of-state* as more than fifty (50) miles beyond Georgia's borders. This definition applies to all "out-of-state" references indicated in this manual**.**

Rev 4/20 Under the ETS program, the term *out-of-area is defined* as more than fifty (50) miles from the member's place of residence. This definition applies to all out-of-area references indicated in any section of this manual**.**

All services covered under the ETS program must have prior authorization before services can be rendered and before reimbursement can be made.

Severability Clause

If any provision or any portion of any provision of this Manual conflicts with State law, federal law or federal regulation or is otherwise held invalid the other provisions of this Manual and the remaining portions of said provision shall not be affected thereby and shall continue in full force and effect.

General Reimbursement Principles

*Prudent Buyer***.** The Department's goal is to make quality health care services available to all eligible members. To maximize allocated funds, the Department has employed the concept of the "Prudent Buyer." Briefly stated, if two different plans of treatment will meet the need of the member, the less expensive treatment should be employed, all other conditions being equal. The vendor associated with the ETS program should apply the same principle in providing services to Medicaid members.

Collection Agencies. Federal law prohibits payments for Medicaid services to anyone other than a provider, except in specified circumstances. Expressly prohibited are payments to collection agencies working on a percentage or other basis unrelated to the cost of processing the billing.

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II. ENROLLMENT

The Department of Community Health requires enrollment in the Medicaid program as a provider prior to being reimbursed for services rendered to Medicaid members. Medicaid Provider ID numbers are issued only to DFCS for purposes of the ETS program and must be indicated on claims (CMS-1500, in addition to the NPI) submitted for reimbursement, web-based transactions, Medicaid forms, and for all other Medicaid activities. Provider ID numbers must be revalidated periodically as required by DCH and completed on-line. Enrollment information and required forms can be found on-line at www.mmis.georgia.gov. Provider numbers that are not revalidated by the due date may be suspended or terminated.

DFCS is subsequently reimbursed by DCH for covered services. **Appendix B** of this manual lists covered modes of transportation and reimbursement rates for covered services under the ETS program.

Effective July 1, 2019, DCH began enrolling the DFCS Regional Accounting Offices in lieu of each local County DFCS office in the Medicaid program. The Department does not enroll transportation providers to participate in the ETS program.

III. GENERAL CONDITIONS OF PARTICIPATION

As general conditions of participation, DFCS must:

1. Comply with State and federal statues, policies and regulations applicable to the Medicaid Program;

2. Provide services in compliance with Title VI of the Civil Rights Act of 1964, as amended. Title VI provides that no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance;

3. Provide services in compliance with Section 504 of the Rehabilitation Act of 1973 and the American with Disabilities Act of 1990 (ADA). Section 504 provides that no otherwise qualified handicapped individual shall solely by reason of his or her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance;

4. Not intentionally or negligently damage or endanger the health, safety or welfare of any member;

5. Not engage in any illegal activities related to the furnishing of services.

6. Adhere to all the applicable policies and procedures of the Department.

7. Notify the Department of any of the following changes immediately (if applies):

    a. Change in business and/or email address, telephone and/or facsimile number;
    b. Change in corporate status or nature;
    c. Change in business location;
    d. Change in solvency;
    e. Change in corporate officers, executive employees, or corporate structure;
    f. Material changes in ownership (i.e., more than 25% a month); and/or
    g. Change in federal employee identification number (ID) or federal tax ID number.

IV. MEMBER ELIGIBILIY

DCH establishes eligibility criteria for Medicaid/PeachCare for Kids benefits based upon federal regulations. The Department contracts with the Department of Human Services' Division of Family and Children Services, and the Social Security Administration to perform eligibility determinations. Individuals and families should be referred to local offices of these agencies for their eligibility determinations. DFCS will verify Medicaid eligibility/enrollment for members requesting ETS.

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Medicaid offers members benefits on a Fee-for-Service (FFS) basis and through Care Management Organizations (CMO) contracted with Medicaid. Medicaid members enrolled in FFS are eligible to participate in the ETS program. Medicaid members enrolled in a CMO are not eligible to participate in the ETS program and must contact their CMO for further information. See Appendix G of this manual.

No special eligibility conditions other than those listed in this manual and in Part 1 Policies and Procedures for Medicaid/PeachCare for Kids Manual are required for member participation in the Exceptional Transportation Services program.

V. PROGRAM REQUIREMENTS

The State office of DFCS is responsible for processing ETS requests for eligible Medicaid members upon the request of the member's representative or healthcare provider team and for billing DCH for reimbursement of covered services.

Following the submission of all required documents/approvals, and the completion of an ETS trip, DFCS is required to bill DCH for reimbursement of the cost of those covered expenses associated with the trip in accordance with Appendix B of this manual. Claims must be submitted on a Health Insurance Claim Form CMS-1500 via the Medicaid Management Information System (MMIS) web portal within the required timelines for claims submissions. The assigned Provider ID number issued to the DFCS Regional Accounting Office responsible for billing must be indicated on the claim form. The member who received the ETS services must reside in one of the counties located in that DFCS Region. See Appendix F for instructions on how to complete this form and a sample of the HCFA 1500 claim form.

CHAPTER 600 - DFCS CONDITIONS OF PARTICIPATION

Section 600.1 Conditions of Participation

1. Accept DCH's reimbursement rates as payment-in-full and bill for covered services using the appropriate procedure codes as outlined in **Appendix B** of this manual;

2. DFCS may bill only for prior approved transportation and related services rendered to Medicaid members receiving Medicaid reimbursable health care services;

3. Bill only for transport miles when the member is in transit; and,

4. Submit claims for reimbursement within 6-months from the date of service and as required by DCH for timeliness thereafter, if applicable.

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Section 600.2 Coordination and Arrangements of ETS

The coordination and arrangement of ETS services shall be the responsibility of State DFCS, which will work with the member, the member's healthcare team and AHS to obtain the required information. All ETS services below require prior authorization by AHS.

Responsibilities shall include but may not be limited to the following:

1. Verify that the member is enrolled in Georgia Medicaid and eligible for ETS. The Medicaid Management Information System (MMIS) web portal and call center will be able to provide information about a member's Medicaid eligibility and health plan enrollment;

2. Determine that the need for ETS exists;

3. Determine and coordinate the least costly means of out-of-state transportation that meets the needs of the member;

4. Coordinate out-of-state automobile transportation (if applicable) by volunteer drivers;

5. Coordinate local taxi transportation (if applicable) to access commercial bus, train or airplane transport out-of-state;

6. Coordinate out-of-local service area taxi service (if applicable) used in conjunction with a commercial bus, train or commercial airplane out-of-state;

7. Coordinate out-of-state travel by commercial bus or train;

8. Coordinate out-of-state travel by commercial airplane;

9. Coordinate city transit when used in conjunction with ETS. The DFCS may issue tokens or the cost of fare for members who are able to ride public transportation in order to access a commercial bus, train or airplane (see Appendix B); and,

10. Coordinate provision of services supportive to transportation that may include:

    a. Parking and tolls for automobile transportation out-of-state;
    b. Lodging and meals out-of-state for member (provided member is not on an in-patient basis in medical facility) and one (1) escort;
    c. Lodging and meals in-state for member (provided member is not on an in-patient basis in medical facility) and one (1) escort while receiving medical care out-of-area of residence**.**
    d. Member and one (1) escort for transportation services out-of-state. The DFCS must obtain prior authorization for escorts who accompany members out-of-state. *Transportation needs* for in-state and within 50 miles of Georgia's border under the ETS program are not covered. The member and escort when necessary may arrange for transportation with the NEMT Broker assigned to the member's county of residence if the member is eligible to receive NEMT services.
    e. Escort for member when traveling out-of-state.

CHAPTER 700 - PRIOR AUTHORIZATION REQUIREMENTS

Section 700.1 Prior Authorization for *Medical Treatment*

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As a requirement for ETS services, there must be a separate prior authorization from AHS for the medical treatment that coincides with the dates of service requested for ETS services. This

request must be obtained from the member's physician and is not the responsibility of DFCS. For information on how to obtain prior authorization for medical treatment, healthcare providers should reference their Medicaid program policies and procedures manual for instructions.

Section 700.2 Conditions to Obtain Prior Authorization

As a condition of reimbursement, prior authorization must be obtained before requests are finalized and prior to the time services are rendered. Members and/or their representatives shall notify DFCS at least ten (10) business days in advance of date(s) of service if possible. If the member requires health care services from more than one out-of-state healthcare provider along with transportation to each healthcare provider, a separate prior authorization must be obtained for transportation to each healthcare provider. Prior authorization may be given for the duration of planned treatment as indicated on the medical certification form, but not for more than one (1) year.

Prior authorization pertains to medical necessity only and does not guarantee reimbursement. In order to be reimbursed for ETS covered and prior approved services, the Medicaid member must be eligible for Medicaid at the time services are rendered.

If there is insufficient time to submit a written request prior to the date of service, the DFCS must call AHS with the information requested on the DMA-322 for authorization prior to the date of service. However, the DMA-322 must be completed and faxed by DFCS to AHS following the telephone request. DFCS must make every effort possible to submit a written prior authorization request as soon as possible. Telephone requests should only be used as a last resort.

When prior authorization cannot be obtained due to the inability of DFCS to anticipate the need for services requiring prior authorization, a telephone call must be made to AHS the next business day following the date that the service was rendered. If the request is approved, form DMA-322 must be completed and sent to AHS immediately following the telephone authorization.

Section 700.3 Documentation Required to Obtain Prior Authorization

DFCS shall request and maintain such records as are necessary to fully disclose the extent of services provided to the member and/or escort and. DFCS is required to furnish such records to the DCH regarding payment of claims as requested by DCH. All service records must include the following information:

a. member's name, address and Medicaid number;
b. member's point of origin and destination;
c. date of transportation service;
d. escort's name, address, and relationship (if escort is required);
e. number of miles traveled and mode of transportation required;
f. service provider's name, address and Medicaid provider number;

g. medical certification or physician statement indicating the reason for the member's medical treatment to include diagnosis code (see Appendix C). The certification must be signed by a Physician or Registered Nurse (R.N.) If the physician or R.N. is unavailable, the certification form may be signed by a Licensed Practical Nurse (L.P.N.), or other licensed health professional of member's health care team.

h. a copy of a properly signed prior authorization from AHS;

i. meals and lodging requests for member and escort, if applicable.

j. A current W-9 form (*Request for Taxpayer Identification Number and Certification)* completed and signed by the member or member's representative.

k. DMA-322 ETS Prior Authorization Request (to be completed by DFCS);

To request ETS services, members or their representative must contact the DFCS State office at 404-657-7543. The DFCS State Office Medicaid Policy Unit must complete the Exceptional Transportation Prior Authorization Request form, DMA-322 (02/20) and fax it to AHS at 678-527-3710. AHS will notify DFCS of the decision to authorize or not authorize the request.

For informational purposes, the ETS PRIOR AUTHORIZATION FORM DMA-322 (04/20) is available on the web at www.mmis.georgia.gov under *Provider Information, Forms for Providers.* This form is to be completed by DFCS. Please see the sample form with instructions in Appendix A of this manual. This form has been updated as of April 2020.

CHAPTER 800 - SCOPE OF SERVICES

Section 800.1 Covered Modes of Transportation

ETS services does not provide the mode of transportation for the member when traveling out-of-state, rather the cost of utilizing that mode of transportation. The most cost-effective mode of transportation appropriate to meet the needs of the member shall be used. Covered modes of transportation include:

1. Airplane - any commercial airplane.
2. Automobile/Van - standard four-wheel vehicle.
3. Bus - any commercial bus or city transit vehicle.
4. Taxi - an automobile properly licensed and equipped as a commercial cab.
5. Train - a commercial train or city transit train.
6. Pickup Truck – a light vehicle with an open body and low sides. The member must ride in the cab.

Section 800.2 Covered Services

Services covered under the ETS program are listed below. All covered services require prior authorization.

Meals. Meals are covered during out-of-state travel and while receiving in-state services for the member (provided member is not on an in-patient basis at medical facility) and one escort when an escort is required. Receipts or confirmation of expenses are required to be on file for reimbursement. The rates and terms are provided in Appendix B of this manual and under the conditions listed below.

a. Breakfast - when travel begins before 6:30 a.m.;
b. Lunch - when member is away from home at least thirteen (13) hours; and
c. Evening - when travel extends beyond 7:30 p.m.

Lodging. Lodging is covered for the member (provided member is not on an in-patient basis at an medical facility) and one escort, when an escort is required in conjunction with in-state or out-of-state travel at a rate and terms provided in Appendix B of this manual. Receipts or confirmation of expenses are required to be on file for reimbursement.

Parking and toll fees. Parking and toll fees are covered at a rate and terms provided in Appendix B of this manual. Receipts or confirmation of expenses are required to be on file for reimbursement.

Taxi. The use of a taxi is covered. Taxis are reimbursed at a rate and terms provided in Appendix B of this manual.

Commercial Airplane. Commercial airplanes are covered and reimbursed at a rate and terms provided in Appendix B of this manual.

Bus (commercial or city transit). Commercial or city transit buses are covered at a rate and terms provided in Appendix B of this manual.

Automobile/Van. Automobile/Van is covered and reimbursed at a mileage rate and terms provided in Appendix B of this manual. Multiple passenger transportation is encouraged. Volunteer drivers of automobiles may be reimbursed from their home to the member's home and return for up to twenty (20) miles. Volunteer drivers may be reimbursed for a return trip when the member is admitted to the hospital or for the unloaded mileage incurred for travel to pick up the member upon discharge from the hospital.

Train. Transportation by train is covered at a rate provided in Appendix B of this manual.

Escort Services. ETS covers one (1) escort and must be prior approved. See Section 800.3.

Travel for foster parent. DFCS will coordinate travel for a Foster parent transporting Medicaid eligible foster child by automobile. DFCS will reimburse the foster parent for covered expenses, and subsequently be reimbursed by the DCH.

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Section 800.3 Requirements for Escort Services

An escort is defined as an individual, whose presence is required to assist a member during transport and while at the place of treatment. An escort must be of an age of legal majority recognized under Georgia law and is typically a relative, guardian or volunteer. ETS covers one (1) escort. All escort services regardless of mode of transportation must have prior authorization.

Escort services for automobile transportation. Medicaid members requiring an escort must be under the age of 21, blind, deaf or mentally retarded or otherwise certified unable to travel alone. This service is utilized, and mileage reimbursement provided when one (1) escort is required out-of-state in conjunction with automobile transportation. There must exist an identifiable need for the escort. Only one escort is covered per member in need. For members under 21 years of age, a parent or guardian may be required to accompany a young child or teenager who will be receiving medical treatment.

Escort services for Medicaid members over 21 years of age must have a physician's statement attesting to the need for an escort because the member is:

a. Blind;
b. Deaf;
c. Mentally Retarded: or
d. Other (as medically certified)

Prior authorization to provide an escort for automobile transportation is required for any other condition not listed above. A Medical Certification form must be submitted (see Appendix C of this manual).

Escort services for commercial bus, train and airplane transportation. Prior authorization for escorts is required. Medicaid members requiring escorts for this type of transportation must also meet the conditions described herein. Escorts required for other conditions not listed also requires prior authorization. DCH will reimburse the cost for this mode of travel for both the member and escort combined at the maximum rate referenced in Appendix B. Codes A0110 or A0140 must be used for billing these types of escort services.

Escort services for taxi. There must exist an identifiable need for the escort.

Section 800.4 Service Limitations

1. A maximum of one (1) passenger round trip may be reimbursed per date of service per member for ETS.

2. Reimbursement for escorts is limited to one member when two or more members are escorted to the same medical facility, on the same date of service, by the same escort.

3. Reimbursement for meals and lodging for a member and one escort when required in conjunction with in-state or out-of-state travel.

4. Transportation services for a parent or guardian out-of-state to visit his or her child member who is an inpatient in a hospital may be covered if the parent or guardian is an eligible Medicaid member. Travel may be limited. Prior authorization is required.

Section 800.5 Non-Covered Services

1. Any travel when the Medicaid member is not an occupant of the vehicle, except for travel via an automobile driven by a volunteer driver up to a total of twenty (20) miles between the driver's home and the member's home and return.

2. Meals and lodging for volunteer drivers.

3. Transportation for educational purposes, vocational training, social services or for any other services not covered by Medicaid, and transportation services to attend amusement parks, sporting events, and other social functions.

4. Services for which prior authorization is required but was not obtained.

5. Services which are not medically necessary, or which are not provided in compliance with the provisions outlined in the ETS policy manual.

6. In-state transportation provided by the NEMT broker.

7. Meals and lodging not provided in conjunction with in-state travel coordinated by the NEMT broker or out-of-state travel coordinated by DFCS.

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8. Emergency transportation (i.e., air ambulance, etc.).

9. Transportation to and from medical appointments within the state of Georgia and no more than 50 miles beyond Georgia borders is not covered under the ETS program. Eligible members may coordinate transportation through the Medicaid's Non-Emergency Medical Transportation (NEMT) program. Members must contact the NEMT Broker assigned to the county in which the member resides provided they are eligible to participate in the NEMT program. Please refer to the NEMT policies and procedures manual for more information.

10. ETS does not include healthcare service providers within fifty (50) miles of the State's border counties that are utilized for routine care by members living in Georgia's border counties or to Medicaid Participating Non-Georgia Hospitals, which have been designated as exceptions to the fifty-mile limit for certain districts (see Appendix E).

CHAPTER 900 - BASIS FOR REIMBURSEMENT

Section 900.1 Reimbursement

The Division will pay the lower of the submitted charge by DFCS for ETS services or the maximum allowable amount as indicated in Appendix B of this manual. Fees are established by

the Division after examination of provider charge patterns, review of information compiled by other state agencies and states, and review of pertinent cost information.

The Division reimburses DFCS for ETS services rendered at rates established by the Division and in accordance with the policies and procedures outlined in this manual (see Reimbursement Rates in Appendix B).

Section 900.2 National Correct Coding Initiative (NCCI)

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The Center for Medicare and Medicaid Services (CMS) has directed all State Medicaid agencies to implement the National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010.

Georgia Medicaid uses NCCI standard payment methodologies. NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

For additional questions regarding the NCCI or MUE regulations, please see the CMS website: http://www.cms.gov/.

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General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 (02-12) forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the

ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny. **For the NEW CMS-1500 (02-12) claim form:**

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

Section 900.3 Reimbursement Methodology

The Division will reimburse necessary medical services only after the transportation has been provided. No transportation expenses should be billed to the Division prior to service provision.

Trip mileage, parking and toll fees are reimbursed for all automobile transportation out-of-state. For the volunteer driver of automobile transportation, the Division reimburses for mileage from the driver's home to the member's home and return for up to a total of twenty (20) miles. The Division reimburses the volunteer driver for mileage from the scheduled hospital appointment when the member is admitted to the hospital or for the unloaded mileage incurred for travel to pick up the member upon discharge from the hospital.
A trip is defined as the loaded mileage from the point of pick-up for the Medicaid member to the destination or drop-off point.

The Division reimburses for mileage for an escort when an escort is required to travel with a member by taxi or automobile.

The Division reimburses for the cost of ticket for out-of-state commercial bus, train or airplane, but not to exceed the maximum allowable amounts as stated in Appendix B of this manual. The cost of the commercial ticket is reimbursed for an escort when the services of an escort are required. However, the cost for both tickets (member and escort) shall not exceed the maximum allowable outlined in Appendix B.

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CHAPTER 1000 – REPORTING MEDICAID FRAUD & ABUSE

Fraud**:** Knowing and willful deception or misrepresentation, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Abuse**:** A manner of operation that results in excessive or unreasonable costs to the Department's Medical programs.

The Department of Community Health's Office of Inspector General investigates possible Medicaid/PeachCare for Kids fraud and abuse cases. The Program Integrity (PI) Section is responsible for appropriate follow-up on all information regarding fraudulent or abusive provider and/or member activities.

The investigation of provider activities includes, but is not limited to, billing for services not rendered by the provider, up coding, and illegal use of the provider number. The investigation of member activities includes but are not limited to, illegal use of Medicaid/PeachCare ID cards and disclosure of resources. The primary responsibility of PI is to develop cases for referrals\to the State Healthcare Fraud Unit or the appropriate district attorney for prosecution.

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DFCS, NEMT Brokers, Medicaid members, providers or other individuals who have information regarding possible fraud and abuse should contact DCH Office of Inspector General (Fraud and Abuse) at the:

Department of Community Health
Office of Inspector General
2 Peachtree Street, NW 5th Floor
Atlanta, GA 30303
404-463-7590 • 800-533-0686
E-mail: oiganonymous@dch.ga.gov (Anonymous), Submit online at https://dch.georgia.gov/send-reports-fraud-abuse (Not Anonymous).

ETS APPENDICES

APPENDIX A

INSTRUCTIONS FOR COMPLETING THE EXCEPTIONAL TRANSPORTATION SERVICES PRIOR AUTHORIZATION FORM, DMA 322 (02/20)

The Exceptional Transportation Prior Authorization Form, DMA-322 (02/20), is to be used for requesting prior authorization from AHS for ETS services. All ETS services require prior authorization. When the member receives health care services from more than one provider, and requires approved transportation to each, a separate prior authorization must be obtained for transportation to each healthcare provider. The form can be downloaded at www.mmis.georgia.gov and is to be completed by DFCS as follows:

Item 1: Transportation Service Provider Name: Enter the name of the service provider, (e.g., Green County DFCS).

Item 2: Phone: Enter the provider's telephone number including area code.

Item 3: Provider Address: Enter the provider's complete address.

Item 4: Provider Medicaid Number: Enter the provider's Medicaid number.

Item 5: Member Name: Enter the member's name exactly as it appears on the member's current Medical Assistance Eligibility Card.

Item 6: Member Medicaid Number: Enter the member's Medicaid number exactly as it appears on the member's current Medical Assistance Eligibility Card.

Item 7: Member's Address: Enter the member's complete address including zip code.

Item 8: Phone: Enter the member's telephone number including the area code, if known.

Item 9: Birth date: Enter the member's birth date by month, day, year, (MM/DD/YY format).

Item 10: Age: Enter the member's age on the date service is to be rendered.

Item 11: Sex: Check the appropriate box.

Item 12: Diagnosis: Enter the member's diagnosis(es), if known.

Item 13: Health Care Provider - Name: Enter the name of the healthcare provider, e.g., Dr. J.T. Jones; Towns Pharmacy; Memorial Hospital; etc.

Item 14: Phone: Enter the healthcare provider's telephone number including area code, if known.

Item 15: HealthCare Provider Address: Enter the healthcare provider's complete address.

Item 16: Transportation Service Request: Check the appropriate box(s) to indicate the service(s) for which prior authorization is being requested. Check all that apply.

Item 17: Check one: One Way or Round Trip.

Item 18: Check one: Member Only or Member and Escort

Item 19: Number of Trips: Enter the number of trips for which prior authorization is requested.

Item 20: Number of Miles: Enter the number of miles when applicable.

Item 21: Length of Stay: Enter the number of days when applicable.

Item 22: Date(s) of Service: Enter the beginning and ending date(s) of service.

Item 23: Amount (used with Y0413/T2002 only): Enter the dollar amount for which prior authorization is requested. The dollar amount should be explained in Item 25, especially when the request is for several services.

Item 24: Circumstances and/or Justification for Requested Services: Give the reason(s) for the transportation request such as the member's physical complaint, mental or emotional state, specific medical care, treatment, or condition which necessitates the mode of service requested.

Item 25: Comments: Enter comments that may further explain the request, a breakdown explaining the dollar amount requested, and the name of the volunteer, airline, bus company, etc.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

EXCEPTIONAL TRANSPORTATION SERVICES PRIOR AUTHORIZATION REQUEST*

Include this Number On All Claim Forms ---- →	PRIOR APPROVAL NUMBER
Prior Approval Expires	

Send Completed Forms To: **Alliant-GMCF, P. O. Box 105329, Atlanta, GA 30348**

Requested By:

1. TRANSPORTATION SERVICE PROVIDER NAME	**2.** PHONE (Area Code/Number)
3. MAILING ADDRESS	
CITY COUNTY STATE ZIP	**4.** PROVIDER MEDICAID NUMBER

Recipient Information:

5. RECIPIENT ADDRESS (Last, First, Middle Initial)	**6.** RECIPIENT MEDICAID NUMBER
7. RECIPIENT ADDRESS CITY COUNTY STATE ZIP CODE	

8. PHONE (Area Code/Number)	**9.** BIRTHDATE (mm/dd/yy)	**10.** AGE	**11.** SEX ☐ Male ☐ Female
12. DIAGNOSIS (If Known)			

Health Care Provider Information:

13. HEALTH CARE PROVIDER NAME	**14.** PHONE (Area Code/Number)
15. HEALTH CARE PROVIDER ADDRESS CITY COUNTY STATE ZIP CODE	

Description of Service:

16. TRANSPORTATION SERVICE(S) REQUESTED (CHECK ALL THAT APPLY)

- ☐ CODE T2003 – U1 AUTOMOBILE (1st MEMBER)
- ☐ CODE T2003 – U2 AUTOMOBILE (2nd MEMBER)
- ☐ CODE T2003 – U3 AUTOMOBILE (3rd MEMBER)
- ☐ CODE A0100 – TAXI
- ☐ CODE A0100 – U1 TAXI (NON-LOCAL)
- ☐ CODE T2004 – CITY TRANSIT
- ☐ CODE T2001 – ESCORT
- ☐ CODE T2002 – OTHER
- ☐ CODE A0110 – COMMERICAL BUS OR TRAIN (INTERSTATE)
- ☐ CODE A0140 – AIRPLANE
- ☐ CODE A0170 – PARKING/TOLLS FEE
- ☐ CODE A0190 – MEALS (MEMBER OUT-OF-STATE)
- ☐ CODE A0190 – U1 MEALS (MEMBER IN-STATE)
- ☐ CODE A0180 – LODGING (MEMBER OUT-OF-STATE)
- ☐ CODE A0180 – U1 LODGING (MEMBER IN-STATE)
- ☐ CODE A0210 – MEALS (ESCORT OUT-OF-STATE)
- ☐ CODE A0210 – U1 MEALS (ESCORT-IN-STATE)
- ☐ CODE A0200 – LODGING (ESCORT OUT-OF-STATE)
- ☐ CODE A0200 – U1 LODGING (ESCORT IN-STATE)

17. CHECK ONE	**18.** CHECK ONE
☐ ONE-WAY	☐ RECIPIENT ONLY
☐ ROUND TRIP	☐ RECIPIENT & ONE ESCORT

19. # OF TRIPS	**20.** # OF MILES	**21.** LENGTH OF STAY # of DAYS	**22.** DATE(S) OF SERVICE From / / Through / /	**23.** AMOUNT

24. CIRCUMSTANCES AND/OR JUSTIFICATION FOR REQUESTED SERVICES

25. COMMENTS

DMA USE ONLY	**26.** APPROVED ☐	**OR**	**27.** DENIED ☐	**28.** REASON DENIED
	29. SIGNATURE		**30.** DATE	***Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of service.***

DMA-322 Rev. (02/20)

APPENDIX B

ETS BILLABLE SERVICE CODES, DESCRIPTIONS AND REIMBURSEMENT RATES
(Prior Authorization is Required for All of the below)

Description	National Service Codes	Modifier	Rate
Automobile 1st passenger Out-of-State Travel Use for out-of-state travel when one member is transported or for first member when multiple members are transported	**T2003**	**U1**	**44¢ Per Mile**
Automobile 2nd passenger Out-of-State Travel Use for second member when multiple members are transported out-of-state.	**T2003**	**U2**	**22¢ Per Mile**
Automobile 3rd passenger Out-of-State Travel Use for third and additional members when multiple members are transported out-of-state.	**T2003**	**U3**	**11¢ Per Mile**
Taxi -Local Use for local taxi transportation in conjunction with commercial bus, train or airplane.	**A0100**		**$40 Maximum**
Taxi Out of local service area. Use only with service codes A0110 (Y0408) or A0140.	**A0100**	**U1**	**$50 Maximum**
Commercial Bus or Train Out-of-State Travel	**A0110**		**$300 Maximum**
City Transit Tokens or Cash Fare. Local city transit used in conjunction with out-of-state commercial bus, train or airplane.	**T2004**		**$4 Maximum**

ETS BILLABLE SERVICE CODES, DESCRIPTIONS AND REIMBURSEMENT RATES
(Prior Authorization is Required for All of the below)

Description	National Service Codes	Modifier	Rate
Airplane Out-of-state travel	**A0140**		**$600 Maximum**
Parking/Toll Fees Out-of-state parking and toll fees.	**A0170**		**$5 Maximum**
Lodging - Member Out-of-state lodging.	**A0180**		**Up to $60 Per Day**
Lodging - Member In-state lodging.	**A0180**	**U1**	**Up to $60 Per Day**
Meals - Member Out-of-state meals.	**A0190**		**Up to $36 Per Day**
Meals - Member In-state meals.	**A0190**	**U1**	**Up to $36 Per Day**
Lodging - Escort Out-of-state lodging.	**A0200**		**Up to $60 Per Day**
Lodging - Escort In-state lodging.	**A0200**	**U1**	**Up to $60 Per Day**
Meals - Escort Out-of-state meals.	**A0210**		**Up to $21 Per Day** $4 maximum for breakfast; $6 maximum for lunch; $11 maximum for dinner
Meals - Escort In-state meals.	**A0210**	**U1**	**Up to $21 Per Day** $4 maximum for breakfast; $6 maximum for lunch; $11 maximum for dinner
Other	**T2002**		**$500 Maximum**
Escort - Transportation Use only with Code T2003 U1, U2, U3, A0100, and A0100 U1. (Y0403, Y0404, Y0405, Y0406 and Y0407). Out-of-state escort services.	**T2001**		**10¢ Per Mile**

APPENDIX C

MEDICAL CERTIFICATION FOR ESCORT SERVICES
FOR MEMBERS OVER AGE 21

[ ] Reason For Medical Transportation (e.g., backache, follow-up visit)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Escort is required because member is:
[ ] Blind [ ] Deaf [ ] Mentally Retarded [ ] Other _____

I hereby attest to and certify that the information indicated by checked blocks is complete, true and accurate to the best of my knowledge.

_____
(Print Licensed Health Professional Name/Title) Date

_____
(Licensed Health Professional Signature/Title) Telephone Number
Signature must be legible

DMA-408 (Rev 03/03)

APPENDIX D

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER & CERTIFICATION
FORM W-9

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ - ___ - ____

or

Employer identification number

__ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

APPENDIX E

MEDICAID PARTICIPATING NON-GEORGIA HOSPITALS

ETS does not include healthcare service providers within fifty (50) miles of the State's border counties that are utilized for routine care by members living in Georgia's border counties or to Medicaid Participating Non-Georgia Hospitals, which have been designated as exceptions to the fifty-mile limit for certain districts.

ALABAMA

Hospital	City
East Alabama Medical Center	Opelika
Flowers Hospital	Dothan
Fort Payne Hospital	Fort Payne
Russell County Community Hospital	Phenix City
Southeast Alabama Regional Healthcare	Eufaula
Southeast Alabama Medical Center Hospital	Dothan

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FLORIDA

Hospital	City
Baptist Medical Center	Jacksonville
Baptist Medical Center Beaches	Jacksonville
Baptist Medical Center Nassau	Fernandina Beach
ED Fraser Memorial Hospital	MacClenny
Mayo Clinic Florida	Jacksonville
Shands Hospital at the University of Florida	Gainesville
St. Luke's –St. Vincent's Healthcare	Jacksonville
Tallahassee Memorial Regional Medical Center	Tallahassee
University Hospital of Jacksonville	Jacksonville

NORTH CAROLINA

Hospital	City
Angel Medical Center, Inc.	Franklin
Murphy Medical Center	Murphy

APPENDIX E (con't.)

PARTICIPATING NON-GEORGIA HOSPITALS

SOUTH CAROLINA

Hospital	City
Abbeville County Memorial	Abbeville
Aiken Regional Medical Center	Aiken
Anmed Health	Anderson
Baptist Easley Hospital	Easley
Greenville Memorial Hospital	Greenville
Hillcrest Hospital	Simpsonville
Shriner's Hospitals for Children	Greenville

TENNESSEE

Hospital	City
Cleveland Tennessee Hospital	Cleveland
Coffee Medical Group	Manchester
Copper Basin Hospital	Copperhill
East Ridge Hospital	Chattanooga
Erlanger Medical Center	Chattanooga
Memorial Hospital	Chattanooga
Parkridge Medical Center	Chattanooga

APPENDIX F

INSTRUCTIONS FOR COMPLETING THE HEALTH INSURANCE CLAIM FORM CMS-1500 (02-12)

The CMS-1500 (02-12) is the appropriate claim form to file for reimbursement of ETS. DFCS should complete this form and forward it for processing within six months from the month of service. The instructions provided for completion of the CMS-1500 (02-12) follows the guidelines as set forth in the Department.

Item 1 — Health Insurance Coverage
Check the appropriate box (Medicaid)

Item 1a — Insured's ID Number
Enter the member's Medicaid number exactly as it appears on the eligibility card.

Item 2 — Patient's Name
Enter Medicaid member's name exactly as it appears on the eligibility card, last name first.

Item 3 — Patient's Birthdate and Sex
Enter member's 8-digit date of birth (using the MM/DD/YYYY format) and gender.

Item 4 — Insured's Name
If Medicaid is primary, leave blank. No entry required unless the member is covered by other insurance.

Item 5 — Patient's Address
Enter member's full correct address including the street number and name, city and zip code.

Item 6 — Patient's Relationship to Insured
Enter relationship, if applicable.

Item 10a-10c — Is Patient's Condition Related To
When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked.

Item 12 — Patient's or Authorized Person's Signature and Date
Enter the signature and date using the MM/DD/YY format or MM/DD/YYYY format.

Item 14 — Date of Current Illness, Injury and/or Pregnancy (LMP)
Enter date in MM/DD/YY format or MM/DD/YYYY format. Use Qualifiers: 431 (Onset of Current Illness); 484 (LMP); or 453 (Estimated Delivery Date).

Item 15 — Other Date
Enter date in MM/DD/YY format or MM/DD/YYYY format.

Item16 Date Patient Unable to Work
Enter date in MM/DD/YY format or MM/DD/YYYY format.

Item 21 Diagnosis or Nature of Illness or Injury
Enter the ICD indicator (the vertical, dotted lines in the upper right-hand portion of the field) to identify ICD-10 code being reported.

Item 23 Prior Authorization Number
Enter the prior authorization number or pre-certification number (PA/PC) issued by AHS, if applicable.

Item 24a Date(s) of Service
Enter first Date of Service (DOS) in the "From" space and the last DOS in the "To" space. If services are only for one date, enter the date twice using the MM/DD/YY format.

When travel is round trip or is via bus train or airplane (codes A0110 or A0140) and extends beyond one day, enter only the date on which the travel began in both the "From" and "To" columns. Taxi, (codes A0100 and A0100 (U1), must be billed in combination with bus, train or airplane (codes A0110 or A0140).

When procedure codes T2003 (U1), T2003 (U2), T2003 (U3) , A0180, A0190, A0200 and A0210 are billed for more than one day, enter the date the service began in the "from" column and the last date the service was provided in the "To" column.

Item 24b Place of Service
Enter "99" for place of service.

Item 24c EMG
Identifies if the service was an emergency.

Item 24d Procedure/Services/Supplies
Enter appropriate procedure code and modifier (if applicable) from those listed the Appendix B of the Policies and *Procedures for Exceptional Transportation Services* Manual. ***Do not use any other codes.***

Item 24e Diagnosis Pointer
Enter the number the diagnosis code reference letter (pointer) as shown in item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. Diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.

Item 24f Charges
Enter the total charge(s) for procedure/services/supplies.

Item 24g Days/Units

When procedure codes T2003 (U1), (U2), (U3) or T2001 are billed, enter the total number of loaded member mileage in this column. Mileage for round trips should be totaled and entered with only one service code.

Procedure code T2001 should be billed on ***one*** line with the total member mileage for the round trip in this field. If the escort only goes one-way, mileage billed should reflect a one-way trip.

When procedure codes T2004, A0180, A0180 (U1), A0190, A0190 (U1), A0200, A0200 (U1), A0210 or A0210 (U1) are billed, enter the total number of days that the services were provided.

When billing procedure codes A0100, A0100 (U1), A0110, A0140 or A0170, enter "1" in this field (do not bill these procedure codes for multiple dates of service).

Item 24j Rendering Provider ID #
The individual rendering the service should be reported in 24j.

Item 25 Federal Tax ID Number
Enter Social Security Number (SSN) or Employee Identification Number (EIN).

Item 28 Total Charge
Enter the total of the charges listed for each line.

Item 29 Amount Paid
Enter only the total amount paid by other insurance.
Note: Do not enter Medicaid copayments collected at the time of service into this field.
Note: Do not enter Medicare payment information in this field.

Item 31 Signature of Physician or Supplier Including Degrees or Credentials and Date
The signature must be that of the provider or the person authorized to sign. Enter the current date.
Note: Unsigned invoice/claims forms cannot be accepted for processing.

Item 33 Billing Provider Information and Telephone Number
Enter the provider's full name (county DFCS office), complete address and telephone number.
Enter the Medicaid provider number in 33b

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

APPENDIX G

Rev. 7/21

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The three licensed CMOs:

Amerigroup RealSolutions in healthcare Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	peach state health plan Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	CareSource CareSource 1-855-202-1058 www.caresource.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All three CMOs are State-wide.**

The Department of Community Health has contracted with three CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult

511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged

222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind

291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate

915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL TECHNOLOGIES at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL TECHNOLOGIES will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL TECHNOLOGIES provider reps will provide training and assistance as needed. Providers may contact GAINWELL TECHNOLOGIES for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL TECHNOLOGIES in error:

GAINWELL TECHNOLOGIES will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN #	GROUP #	Helpdesk
Amerigroup Community Care	IngenioRx	020107	HL	WKJA	1-833-235-2031
CareSource	Express Scripts (ESI)	003858	MA	RXINN01	1-800-416-3630
Peach State Health Plan	CVS	004336	MCAIDADV	RX5439	1-844-297-0513

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL TECHNOLOGIES by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL TECHNOLOGIES will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates:

Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan
1 (800) 454-3730	1 (855) 202-1058 1 (866) 930-0019 (fax)	1 (866) 399-0929

APPENDIX H

ETS In-State Out-of-Area Services Request for Authorization

Date of Request _____

Member ID _____Member Name_____
_____

Georgia Requesting Provider ID_____Provider Name_____

Rendering Physician Information

In-State Out-of-Area Provider Name _____
Specialty _____Phone _____Ext. _____Fax_____
Address _____
City _____ State _____ Zip_____

Rendering Facility Information

In-State Out-of-Area Provider Name _____
Specialty _____Phone _____Ext. _____Fax_____
Address _____
City _____ State _____ Zip_____

Requesting Agency's Information

Contact Name _____ Phone _____Ext._____
Fax _____ Email _____
Place of Service: ☐Inpatient Hospital ☐Outpatient Hospital ☐Office
Admission Type: ☐Emergency ☐Elective
Admit Date: _____Discharge Date: _____
Release of Information Code: _____ F/U Begin Date: _____ F/U End Date: _____
F/U Appts: ☐Daily ☐Weekly ☐Other: _____

Diagnosis

ICD10 _____ ICD10 Date _____ Primary ☐yes ☐No Admission Diagnosis _____
ICD10 _____ ICD10 Date _____ Primary ☐yes ☐No

Procedures

Code _____ From Date _____ To Date_____ Units _____
Code _____ From Date _____ To Date_____ Units _____

The following Information must be attached to this request:

Letter of Medical Necessity must include:
Current Clinical Summary
Type of Treatment
Estimated length of treatment
Reason for in-state out-of-area request
Anticipated/Scheduled date of service
Indication that requested treatment/service is not available in the member's community/vicinity
Frequency of treatment (if more than 30 days must submit physician letter describing the treatment performed and the treatment to be performed)

Additional medical documentation must include:
Pertinent past medical history/surgery/treatments
Diagnostic reports supporting diagnosis
Psych/Social evaluation (if required)

ATTACH ALL APPLICABLE DOCUMENTATION
(Request cannot be completed or processed if the required documentation is not submitted)

Completed by Medicaid Medical Reviewer
Nurse Reviewer _____ _____Date_____ PA #_____

APPENDIX I



Information for Providers Serving Medicaid Members
in the Georgia Families 360°SM Program

Georgia Families 360°SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the **Georgia Families 360°SM** Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360°SM Every member in **Georgia Families 360°SM** is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations Representative.

To learn more about DCH and its dedication to *A Healthy Georgia*, visit www.dch.georgia.gov.

Rev.
7/20

APPENDIX J

ETS AUTOMOBILE/VAN/TRUCK/DRIVER INFORMATION FORM

ETS is not responsible for providing drivers or vehicles to members when the requested mode of transportation is either an automobile, truck, or van. The member or member's representative must complete the ETS Out-of-State Automobile/Van/Truck Transportation Form of this Appendix. The completed attestation letter must be signed by the driver and submitted to DFCS before the trip in order to receive reimbursement for mileage. Mileage reimbursement will be withheld until the form is completed and submitted to DFCS. Reimbursement for mileage is covered and is referenced in Appendix B. When choosing the driver and desired mode of transportation, the member or member's representative should confirm that the below measures are utilized. Safety is the priority. Some measures suggested include but may not be limited to:

1. Member/escort occupancy for adults should not exceed vehicle manufacturer's approved seating capacity;

2. Vehicle should be parked or stopped curbside so that member/escort does not have to cross streets to get to their destination;

3. Interior and exterior of vehicle should be free of hazardous debris or unsecured items;

4. Passenger windows should not be opened more than 50% when children are in transport;

5. Selected drivers should practice safe driving, observe all public safety traffic laws and drive in a courteous manner;

6. Selected drivers should only use cell phones while driving in accordance with the ***Hands Free Georgia Act***, effective July 1, 2018;

7. Member/escort should be seated while vehicle is in motion and wear seat belts at all times (as required by law) with only one passenger per seat belt where applicable;

8. Selected driver should operate vehicle within manufacturer's safe operating standards at all times and comply with all highway and vehicle operation laws;

9. In case of an emergency or fire, the vehicle should be immediately evacuated and emergency response or 911 called immediately. When possible, selected driver shall evaluate injuries carefully;

10. When transporting children, it is the responsibility of the selected driver and/or the escort, if applicable, to ensure that an approved infant or child car seat or other specially adapted seating (when applicable) is utilized and is appropriate to the age and size of child/member and is in accordance with all applicable laws including Georgia Code Section 40-8-76 G; and,

11. Selected drivers should possess appropriate and valid state issued driver licenses and required insurance to operate vehicle.

ETS AUTOMOBILE / VAN / TRUCK / DRIVER INFORMATION & ATTESTATION FORM

DRIVER INFORMATION

DRIVER'S NAME_____

ADDRESS _____

TELEPHONE NUMBER _____**DRIVER LICENSE NUMBER**_____

NAME OF AUTOMOBILE INSRANCE CARRIER _____

MEMBER INFORMATION

NAME OF MEMBER BEING TRANSPORTED_____
First Middle Initial Last

MEDICAID ID #_____ **PHONE #**_____

ESCORT INFORMATION

ESCORT NAME (if applicable)_____

RELATIONSHIP TO MEMBER_____

TRIP INFORMATION

START DATE & TIME _____ **RETURN DATE & TIME**_____

PLACE OF PICK UP _____

DESTINATION _____

DRIVER ACKNOWLEDGEMENT:

By my signature below, I acknowledge that I have read, understood, and will adhere to the ETS Automobile/Van/Truck Driver Information Sheet attached to this form.

I fully understand and agree that the Department of Community of Health (DCH) and its authorized agents ARE NOT RESPONSIBLE OR LIABLE FOR ANY TYPE OF DAMAGES, INCLUDING DAMAGES ARISING FROM NEGLIGENCE that may occur during my use of the vehicle or to myself, the driver. I further acknowledge that I understand and agree that DCH is solely responsible for the reimbursement of mileage to and from (if applicable) the prior authorized destination.

I hereby certify that I am a duly licensed driver with adequate and appropriate insurance coverage for myself and the vehicle.

_____ _____
Driver's Signature Date