PO Box 12000 | Syracuse, NY 13218
medanswering.com

To: **All Taxi Transportation Providers**

From: **MAS on behalf of NYSDOH Bureau of Medicaid Transportation**

Subject: **Taxi Preferred Provider Opportunity Crouse Hospital Chemical Dependency Services PPO Zone 3**

Date: **January 20, 2019**

The New York State Department of Health (DOH) is pleased to offer a Taxi Preferred Provider Opportunity (PPO) for trips being arranged for eligible NYS Medicaid enrollees to/from Crouse Hospital Chemical Dependency Services located at 410 S Crouse Ave, Syracuse, NY 13210.

The PPO includes providing non-emergency Taxi transportation for Medicaid enrollees' trips traveling to/from Crouse Hospital Chemical Dependency originating or ending in Zone 3. Please refer to page 2 of Crouse Hospital Chemical Dependency Services Zone 3 trip sample for all included zip codes.

There will be one transportation provider (TP) selected to fulfill the responsibilities associated with this PPO. The selected TP will receive a flat rate per enrollee for each trip leg the enrollee is transported. The PPO rate is inclusive of all services associated with the defined modality in accordance with DOH Policy.

The selected TP must be an approved NYS Medicaid Transportation Provider and comply at all times with New York State's rules and regulations.

Interested TPs must complete and submit the attached proposal by the required due date.

Please note MAS reserves the right to contact the TP for clarification on questions regarding their PPO application.

A three-month trip sample is provided for your review, however, please understand this data does not guarantee future trip volume.

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TAXI PREFERRED PROVIDER OPPORTUNITY
for
CROUSE HOSPITAL CHEMICAL DEPENDENCY SERVICES PPO ZONE 3
410 S CROUSE AVE, SYRACUSE, NY 13210

PROPOSAL

*All proposals must be completed, signed, scanned and emailed to: ppo@medanswering.com by 4 PM on **2/3/2019**.*

Transportation Company Name:_____

Owner/General Manager:_____

Email:_____ **Provider ID:**_____

SECTION 1: Proposed Flat Rate Charge Per Person/Per Trip Leg

Flat rate: _____

SECTION 2: Required Information

1. Do you have a Medicaid Compliance Program as required by NYS Office of Medicaid Inspector General?

   Yes _____ No _____

2. Are all vehicles used by your company for transporting Medicaid enrollees properly owned/leased, registered and insured as Taxi vehicles according to NYSDOH Policy?

   Yes _____ No _____

3. How many properly owned/leased, registered and insured Medicaid Taxi vehicles are in your fleet?

   Number of Vehicles: _____

4. If your company is not currently providing service 24 hours/day, 7 days/week, 365 days/year, is your company able to provide 24/7/365 service for this PPO?

   Yes _____ No _____

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SECTION 3: PPO Requirements

1. Assigned trips may not be refused.
2. Assigned trips may not be reassigned.
3. The Transportation Provider (TP) will be available 24 hours/day, 7 days/week, 365 days/year.
4. TP must accept all trips assignments electronically via the MAS Medicaid Transportation Management System (MAS System). There will be no calls or faxes from MAS.
5. For all scheduled trips, the TP must be on time for pick-ups & drop offs (within 15 minutes of the scheduled time).
6. All immediate trip requests must be picked up within 60 minutes of the MAS trip assignment.
7. TP leadership must attend all pre and post meetings and/or conference calls with DOH, MAS and Crouse Hospital Chemical Dependency Services.
8. In order to meet the high-quality expectations of the DOH and Crouse Hospital Chemical Dependency Services, the TP will commit to honoring agreements between these two entities to ensure exceptional results. Such agreements may include, but not be limited to, on-time performance, proper dress code, company identification, employee ID, pick up and drop off locations, adhering to protocols, quick and easy mutual access to organizational leadership in order to address real-time problem solving and long-term planning.
9. Additional guidelines as agreed to by Crouse Hospital Chemical Dependency Services and the transportation provider.

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SECTION 4: Additional Information

In the box below, please include any additional comments relative to the services you provide that should be considered by Crouse Hospital Chemical Dependency Services and NYSDOH during the selection process.

PRINT NAME (Owner/General Manager)

SIGNATURE (Owner/General Manage) **DATE**