Public Transportation Automated Reimbursement (PTAR) Program
Application Profile

PART I: PTAR Facility Information												
Facility's Legal Name:												
Facility National Provider Identifier (NPI)												
Facility NY Medicaid Identification Number												

PART II: ADMINISTRATOR CONTACT INFORMATION	
PTAR Administrator	
Email Address	
Telephone Number	
Comments	

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PART III: Location of Each Facility That Will Dispense MetroCards (MAIN AND OFFSITE LOCATIONS)								
Facility Location Name								
Facility NY Medicaid Identification Number								
Transportation Liaison								
Email Address								
Telephone Number								
Fax Number								
Facility Location Name								
Facility NY Medicaid Identification Number								
Transportation Liaison								
Email Address								
Telephone Number								
Fax Number								

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PART III (cont.)								
Facility Location Name								
Facility NY Medicaid Identification Number								
Email Address								
Telephone Number								
Fax Number								
Facility Location Name								
Facility NY Medicaid Identification Number								
Email Address								
Telephone Number								
Fax Number								

PART IV: CERTIFICATION STATEMENT (MUST BE COMPLETED BY AUTHORIZED REPRESENTATIVE)

CERTIFICATION STATEMENT
PAYMENTS MADE TO MEDICAID ENROLLEES FOR OUT-OF-POCKET MEDICALLY RELATED TRAVEL EXPENSES

I,

(Name of Authorized Representative)

(Name of Facility)

certify that:

- The facility named above, hereafter in this certification referred to as the "Facility," is actively enrolled with and authorized to participate in the New York State Medicaid Program;
- Payments made by the Facility to Medicaid enrollees (for out-of-pocket expenses incurred traveling to necessary medical care), on behalf of the New York State Health Department, are made in accordance with established rules, fee schedules and procedures;
- All records pertaining to the reimbursement of out-of-pocket travel expenses reimbursed by the Facility to Medicaid enrollees will be kept for a period of six (6) years from the date of payment and such records and information regarding such claims therefore shall be promptly furnished upon request of the New York State Health Department and/or its agents; the Office of the Medicaid Inspector General and/or its agents; the State Medicaid Fraud Control Unit of the Office of the Attorney General; and/or the Secretary of the Department of Health and Human Services and/or its agents.

I understand and agree that the Facility shall be subject to and bound by the rules of the New York State Health Department. My signature on the face hereof incorporates the above certifications and attests to their truth.

Signature of Representative	Date
Printed Name of Representative	Date