NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM

GROUP TRANSPORTATION PRIOR APPROVAL

1. TREATMENT CENTER PROVIDER NUMBER	2. NAME ADDRESS TELEPHONE	4. BEGINNING DATE M M D D C C Y Y	5. TRANSPORTATION PROVIDER NUMBER	6. NAME ADDRESS GARAGE

7. DESTINATION

	8. CLIENT ID	9. PROCEDURE CODE	10. NUMBER OF UNITS	11. CAL DAYS	12. CLIENT NAME	13. ADDRESS	14. WHEEL CHAIR	15. DATE OF BIRTH	16. SEX
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[redacted]

DO NOT STAPLE IN BARCODE AREA

22. FOR OFFICIAL USE ONLY

I certify that the above orders are for trips that are medically necessary at the level of transportation ordered. And that statements on the reverse side apply to this order and are made a part thereof.

17. TREATMENT CENTER AUTHORIZED SIGNATURE	18. DATE M M D D C C Y Y
19. GROUP TRANSPORTATION AUTHORIZED SIGNATURE	20. DATE M M D D C C Y Y

CERTIFICATION

Orderer certifies that: I am (or the business entity named on this form is) a qualified orderer enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this transportation prior approval request; I have reviewed this form. I (or the entity) order or cause to be ordered the services itemized in accordance with applicable federal and state laws and regulations; ALL STATEMENTS MADE HEREON ARE TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM; I UNDERSTAND THAT PAYMENT FOR THE ORDERED SERVICES WILL BE FROM FEDERAL, STATE, AND LOCAL PUBLIC FUNDS AND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; all records pertaining to the ordering of these services including all records which are necessary to disclose fully the extent of care, services, and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and as such records and information regarding this ordered service shall be promptly furnished upon request to the local or State Department of Health, the State Medicaid Fraud Control Unit, or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex, and religion; I agree (or the entity agrees) to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to accept the data on this form as original evidence of services ordered.

By making this prior approval request I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes, and procedures of the New York State Department of Health as set forth in Title 18 of the Official Compilation of Codes, Rules, and Regulations of New York State and other publications of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services, the Medicaid Management Information System Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, and duly made determination affecting my (or the entity's) past, present, or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the face hereof incorporates the above certifications and attests to their truth.