

BROKER NAME & LOGO

A HCA HIPAA Business Associate

Date: _____

Medical Provider: _____ Fax: _____

Medical Service(s) Authorized: _____

Client Name: _____ ProviderOne ID Number: _____

As a Transportation Broker contracted by the Washington State Health Care Authority (HCA), we arrange transportation to and from medical appointments for eligible Medicaid clients per state requirements. The above client has asked us for transportation assistance and told us that they receive the above medical service from you. Please check the answers that apply to the above client and fax back to us at **[Broker fax #]**.

In addition, we are required by federal Centers of Medicare & Medicaid (CMS) and HCA contract requirements to verify the method of payment for this client's treatment. If the medical service is limited by HCA, please indicate whether you have HCA authorization to provide that service. *Note that payment may be recovered by HCA if treatment/service(s) was not authorized by HCA.

DATE(S) OF SERVICES: _____

PLEASE CHECK ALL THAT APPLY:

I verify that:

___ Treatment/Service(s) for the client is payable by **Medicaid**

___ client's treatment/service(s) is being billed to **Medicare**: _____

___ client's treatment is being billed to another insurance: _____

___ Authorization for treatment/service(s) has been received from HCA

Medical treatment/service(s): _____

Your time and cooperation in this matter are greatly appreciated. **We are a HIPAA Business Associate and authorized by HCA to request this information.** We need minimal information requested on this form to verify that the transportation is for a covered HCA service.

We may deny the client's request for transportation to/from your office/facility until we receive verification from you.

Health/Medical Provider Signature & Date

Thank you;
[Broker Contact Information]