



REQUEST FOR QUALIFICATIONS – PROVIDER’S CREDENTIALS

East Grand Region
 Middle Grand Region
 West Grand Region

CLASSIFICATION

1 (Select One)	New	Anniversary	Renewal	Revision
2 Mode of Transportation:	Ambulatory	Wheelchair	Invalid Vehicle	Ambulance

OWNERSHIP

3 (Check One)	Individual	Partnership	Corporation	LLC
	State Gov.	County Gov.	Hosp.	Non-Profit
4a Name of Owner:			4b Email Address:	
5a Owner Street Address or P.O. Box:			5b Business Phone:	
6a City:	6b State:	6c Zip Code:	6d Fax:	
7a Authorized Agent:			7b Email Address:	
8a Street Address or P.O. Box:			8b Business Phone:	
9a City:	9b State:	9c Zip Code:	9d Fax:	

BASIC QUALIFICATIONS

Have you applied and received your TennCare assigned Provider Number? *If yes, attach documentation and/or write Provider Number here: _____	Yes/No?
Have you applied and received your National Provider Identification (NPI) Number? *If yes, attach documentation and/or write NPI Number here: _____	Yes/No?
10a Has the owner or any party to this application had any certification or license revoked or had any other disciplinary actions levied from any state or federal agency? *If yes, attach documentation explaining the circumstances.	10b Yes/No?
11a Has the owner or any party to this application ever been convicted of a felony by this or any other state or federal court? *If yes, attach documentation explaining the circumstances.	11b Yes/No?
12a Is the owner, or any party to this application currently in any pending matter referred to in the preceding two items? *If yes, attach documentation explaining the circumstances.	12b Yes/No?

OPERATIONAL INFORMATION

13a Name of Service:	13b Number of Vehicles:	
14 Doing Business As:		
15a Business Hours	15b After Hours	15c Long Distance Trips
16a Is the owner or any party to this application currently in a contractual or similar agreement with another agency for the provision of transportation of patients, members and/or clients? *If yes, attach copy of contract/agreement.		16b Yes/No?

17 Contractor/Contractee: (If additional space is needed, attach separate page)

BUSINESS LOCATION (If Different from Ownership's Address)

18a Business Location - Street Address:		18b County:	18c Level of Care:
19a City:	19b State:	19c Zip Code:	19d Zoned Provider:
20a Director:		20b Email Address:	
21a Business Phone:	21b Emergency Phone:	21c Fax:	

ADDITIONAL SATELLITE LOCATION(S) MUST BE RECORDED ON AN ADDITIONAL SHEET OF PAPER

SERVICE AREA INTEREST

22a Service County of Interest:
23a Service City/Area of Interest:
24a Service Facilities of Interest:

REIMBURSEMENT INFORMATION

25a Federal Tax Identification Number:	25b Email Address:
26a Address: Street City State Zip	26b Pick-up Check or Mail Check:

MANIFEST/TRIP REQUEST E-MAILED/FAX TO

27 Agency or Company Name:			
28a Name of Contact Representative:		28b Email Address:	
29a Street Address or P.O. Box:		29b County:	
30a City:		30b State:	30c Zip Code:
31a Business Phone:	31b Emergency Phone:	31c Fax:	

CERTIFICATION

The undersigned certifies that the information contained in this application and all attached documentation is true and correct to the best of my knowledge and belief and that I will comply with Southeastrans, Inc. Rules and Policies, as amended, governing Independent Provider's contract. Provider shall operate as an independent Provider in providing services under this Contract, and not as an agent, representative or employee of BROKER.	
32 Owner's Name:	
33a Signature: (Blue Ink Required)	33b Date:
34 Authorized Agent's Name:	
35a Signature: (Blue Ink Required)	35b Date:

PLEASE FAX THE COMPLETED FORM TO 423-296-1607