

**Division of Medical Assistance
Office of Inspector General Adverse Action Reporting Form**

County:

A. Complete information in 1. – 5. Complete 6. and 8. if the NEMT provider or vendor has a Medicaid Provider Number or an Electronic Tracking Number.

1. Provider Name	
2. Provider Title	
3. Provider SSN	
4. Provider DOB	
5. Provider Business Name	
6. Medicaid Provider Number	
7. Provider Tax ID Number:	
8. Electronic Tracking Number	
9. Provider Physical Address:	
10. Provider Mailing Address:	
11. Type of Business:	<input type="checkbox"/> Van service <input type="checkbox"/> Wheelchair van <input type="checkbox"/> Bus, interstate or intrastate carrier <input type="checkbox"/> Taxi <input type="checkbox"/> Ambulance service <input type="checkbox"/> Other (specify):

B. Explain type of adverse action taken against transportation provider.

Denial Termination Other (specify) _____

C. Explain reason for adverse action taken against transportation provider (attach documentation).

Submitted by: Title:

Submit by mail or fax to: Division of Medical Assistance, Quality Assurance, 2501 Mail Service Center, Raleigh, NC 27699- 2501, Fax #: 919-715-7706

For DMA Use Only	
Adverse action and documentation verified <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments:	
Signed:	Date Referred to Provider Services: