



Dear Recipient:

Thank you for your interest in using an Individual Transportation Participant (ITP). An ITP can be reimbursed for driving you to your health care appointments. The enclosed enrollment packet includes the documents the ITP must submit to Saferide. Refer to the ITP Enrollment Checklist for a list of required items. These items must be processed and approved by the state of Texas. The ITP cannot take any trips until the items are approved.

An ITP could be either of the following:

- ITP (Self): A Medicaid client who transports him/herself to a health care appointment using a personal vehicle OR an individual who transports a family member who is a Medicaid client using a personal vehicle
- ITP (Other): An individual who transports non-family member Medicaid clients to a health care appointment using a personal vehicle; these individuals must undergo a Criminal History check

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The ITP must show on the ITP Information Page if they are applying as “Self” or “Other.” **The required information must only be provided for the person who will be driving.**

Completed documents and other required items should be submitted via mail, email or fax to:

Mailing address: 106 Jefferson St, Suite 300  
San Antonio, TX 78205  
Email address: [itp\\_support@saferidehealth.com](mailto:itp_support@saferidehealth.com)  
Fax: 888-432-0026

Please remember to call Saferide at 1-855-932-2318 before your ITP drives you to any appointments in order to book your appointments in our system. You can request claim forms through any of the above contacts. The form can also be found at <https://www.saferidehealth.com/texas>. Your ITP should use this form to request reimbursement. Make copies of this form for future trips.

If you have any questions about this process, please call 1-855-932-2331.

Sincerely,

Saferide Health

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## Individual Transportation Participant (ITP) Enrollment Checklist Use

this checklist to make sure all the items needed to sign up to be an ITP are completed and submitted. **No trips will be authorized until all documents have been approved.** For help filling out these forms, call SafeRide Health Alternate Transportation department at 855-932-2331.

- A copy of your completed ITP Information Page (pg 2)  
*(Please fill out everything, and mark N/A if a question does not apply.)*
- A copy of your completed Member/ITP Information Page (pg 3)
- The signed Terms & Conditions page (pg 4)
- A copy of your current and valid Driver's License
- A copy of your current and valid auto insurance card  
*(The driver must be listed as a covered driver on the insurance.)*
- A copy of your Social Security card
- A copy of vehicle registration and inspection

**Important:** *The name listed on your driver's license and Social Security card must be the same.*

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For direct deposit options be sure to include a valid email. All electronic payments are sent through Interchecks.

See last page for information regarding Interchecks

**Please make a selection below for preferred payment option**

- Interchecks Payment
- Paper Check

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**All forms must be sent to SafeRide Health via one of the following:**

**Mailing address:**

106 Jefferson St, Suite 300

San Antonio, TX 78205

**Email address:** [itp\\_support@saferidehealth.com](mailto:itp_support@saferidehealth.com)

**Fax:** 888-432-0026

**Note:** *Please retain a copy for your records.*

### ITP Information Page

The purpose of the form is to obtain data to sign up to be an ITP. You must fill out this entire form and sign it. Please use blue or black ink. Original signature only; copies or stamped signature will not be accepted.

|  |  |   |  |
|--|--|---|--|
| <b>ITP Status: Self/Other:</b>   |  | <b>Telephone Number:(if we need to contact you)</b> |  |
| <input type="checkbox"/> Self<br><input type="checkbox"/> Other  |  | (    )  |  |
| <i>Must match Driver's License</i>   |  |   |  |
| <b>Last Name :</b>   |  | <b>First Name:</b>                                  | <b>Middle Initial:</b>                               |
|  |  |   |  |
| <b>Social Security Number:(Please attach copy of card)</b>   |  | <b>Date of Birth:</b>                               |  |
|  |  |   |  |
| <b>Driver's License Number:</b><br><i>(Please attach a copy of driver's license).</i>  |  | <b>License Issue Date:</b><br><i>MM/DD/YYYY</i>     | <b>License Expiration Date:</b><br><i>MM/DD/YYYY</i> |
|  |  |   |  |
| <b>Physical Address:</b> <i>This is where you live. (You must give a street address. PO boxes will not be accepted.)<br/>Number, Street, City, State, and Zip Code</i> |  |   |  |
|  |  |   |  |
| <b>Mailing address: If same as above leave blank</b><br><i>Number, Street, City, State, and Zip Code.</i>  |  | <b>Email Address:</b>                               |  |
|  |  |   |  |

**Important:** *the name on your driver's license, social security card must be the same*

|  |  |   |
|--|--|---|
| <b>Vehicle &amp; Insurance Information</b>   |  |   |
| <b>Vehicle Identification Number (VIN):</b><br><i>Please provide VIN of vehicle used to transport.</i>   |  | <b>License Tag:</b>                                 |
|  |  |   |
| <b>Auto Insurance Policy Company:</b><br><i>Please attach a copy of insurer insurance card.<br/>The vehicle used to transport the member must be listed on insurance policy.</i> |  | <b>Policy Issue Date:</b><br><i>MM/DD/YYYY</i>      |
|  |  | <b>Policy Expiration Date:</b><br><i>MM/DD/YYYY</i> |
|  |  |   |



## Member/ITP Information Page

If you are driving yourself or family members only, fill out **Section 1**, leave **Section 2** blank.

If you are driving a person other than yourself or a family member, fill out **Section 1** and **Section 2**.

### Section 1

**Members Health Plan:** *(Please indicate your health plan)* \_\_\_\_\_

| Member Name: <i>(the person you will be driving)</i> | Medicaid ID #: | Member DOB: <i>MM/DD/YYYY</i> | Relationship to ITP:   |
|--|----------------|-------------------------------|--|
|  |                |                               | <input type="checkbox"/> Family Member/Foster<br><input type="checkbox"/> Non-Family Member<br><input type="checkbox"/> Self |

### Section 2 *(Facts about the ITP)*

**Are you currently charged with or have you even been convicted of a crime (excluding Class C misdemeanor traffic citations)?**

**“Convicted” means that:**

- (a) A judgment of conviction has been entered against an individual by a Federal, State or local court, regardless of whether:
  - (1) There is a post-trial motion or an appeal pending; or
  - (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.
- (b) A Federal, State or local court has made a finding of guilt against an individual.
- (c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual, or
- (d) An individual has entered participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Yes       No

*If Yes, fully explain the details including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*



## Terms and Condition of Participation

1. Before an ITP drives a member, the application must be processed and approved. Once the application process is complete, the member must get approval for the ride from SafeRide Health. The member must call 855-932-2318 to get this approval prior to the trip otherwise the ITP will not get paid.
2. The ITP must maintain a current and valid driver's license, vehicle insurance, vehicle inspection and vehicle registration during each ride.
3. ITP drivers are limited to a total of 10 non-related members to drive for mileage reimbursement under the ITP program. If all the members assigned are directly related family members, the number may exceed 10 but not to exceed 15 total.
4. The mileage reimbursement (payment) amount is based on a mileage calculation computed by SafeRide Health using a nationally recognized system of the shortest distance of the trip and not on the number of members who are given a ride. The ITP will be paid based on the determined mileage at the vehicle mile rate set by the Texas Legislature for state employees that is in effect at the time of the ride.
5. The member must have the doctor sign the ITP Service Record (Claim Form) and the ITP must sign the ITP Service Record (Claim Form). The claim form must be complete with all required information. (An example is sent with the claim forms.)
6. The claim form must be submitted within 95 days from the date of the ride.

### **Attestation:**

*I attest that I have read the terms and conditions of participation as an Individual Transportation Participant (ITP) and that the information provided in this application is true and correct. I understand that I must comply with the terms and conditions of participation and maintain documentation to support any mileage reimbursement claim and that Superior Health or SafeRide Health reserves the right to request and validate documentation being relied upon to support mileage reimbursement claims.*

\_\_\_\_\_  
Signature of Individual Transportation Participant (ITP)

\_\_\_\_\_  
Date



## Payment Options

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### Mileage Reimbursement Payment Options

ITP drivers have the option of receiving their reimbursement payment on a physical check in the mail or through several options using Interchecks. The options include receiving payment electronically on a reloadable prepaid Visa card, a virtual prepaid card or an instant electronic deposit directly in your bank account.

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### Enrolling with Interchecks

When the recipient is first sent a payment, they will receive the below enrollment email. They will need to enroll with their email and the access code provided at <https://www.interchecks.com/site/enrollment/terms>.

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### Receiving Paper Checks

If you wish to receive paper checks please be sure to check the box labeled Paper Check on Page 1 of this packet. Also be sure to include your mailing address if it is different from your physical address.

## Example of Interchecks email



**SafeRide Health**

[itp\\_driver@saferidehealth.com](mailto:itp_driver@saferidehealth.com)

Reference ID: 1234

Account: [itp\\_driver@saferidehealth.com](mailto:itp_driver@saferidehealth.com)

Date: 05-26-2021 09:05 PM ET

Great News!

We have processed a payment from **SafeRide Inc** for **\$1.00**. To accept payment, visit [Interchecks](#).

Enroll in Interchecks to retrieve your payment.

1. Visit [Interchecks](#)
2. Enter your Email Address: [itp\\_driver@saferidehealth.com](mailto:itp_driver@saferidehealth.com)
3. Enter the Access Code: **RKOVWQ**

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Questions concerning this notice? Visit [Interchecks](#).

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