NOT FOR USE FOR HOSPITAL DISCHARGES/TRANSFERS

Howard County Department of Health
Medical Assistance Transportation Grant Program
8930 Stanford Blvd, Columbia Maryland 21045 PHONE: (1 (877) 312-6571 FAX: (410) 313-6315

MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORTION CERTIFICATION FORM

SECTION 1 - PATIENT PERSONAL INFORMATION:

Last Name:	First Name:	Height:	Weight:	DOB:
Address:	City/State/Zip:	**Attendant Required?** ☐ YES ☐ NO		
Bldg or Facility Name: / Room/Bed #	Patient Contact/Phone:			
Medical Assistance #: / Social Security # (If MA# not available):	Medicare #:	Other Insurance:		
Please check environmental conditions that are applicable: _____ RAMP, _____ STEPS If steps, give # _____ **OTHER** _____ ( ) Destination ( ) Point of Origin				
Is this participant staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ Yes ☐ No **(If Yes, limited transportation benefits may be available. Please contact your Local Health Dept. MA Transportation Unit**)				

SECTION 2- List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this participant that requires the participant to be transported in ambulance, wheelchair or Metro rail/bus/sedan and why transport by other means is contraindicated by the participant's condition:

Underlying Medical Diagnosis (Do not enter ICD codes)	Medical Condition (Symptoms)

SECTION 3 – CHOOSE ONLY ONE CLINICALLY APPROPRIATE MODE OF TRANSPORTATION

a) **AMBULATORY/ABLE TO WALK (with mobility aides**) - Enter distance of ambulation in feet:_____
Clinical justification for ambulatory mode of transport: (Justification must include why the public transit system (including paratransit) is not clinically appropriate for the participant):
_____

Client may be transported by:
☐ Paratransit vehicle
☐ Public transit system
☐ Cab/Sedan

b) ☐ **WHEELCHAIR Check Type:** ☐ **REGULAR W/C** ☐ **ELEC. W/C** ☐ **ELECTRIC SCOOTER** ☐ **X-WIDE W/C** ☐ **SPECIALTY W/C**

Please check environmental conditions that are applicable: _____ RAMP, _____ STEPS If steps, give # _____ **OTHER** _____
( ) Destination ( ) Point of Origin
Clinical justification for wheelchair mode of transport: (Justification must include why the public transit system is not clinically appropriate for the participant):
_____

c) ☐ **AMBULANCE - Check Appropriate Level (justify below if other than BLS)** ☐ **BLS** ☐ **ALS** ☐ **SCT/P** ☐ **SCT/N** ☐ **NEO-NATAL**

Clinical Interventions Necessitation Ambulance:_____

NOTE: Ambulance service <u>will not</u> be provided for the purpose of transferring a participant to a bed or examining table.

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the participant must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is **absolutely** contraindicated by the participant's condition.
All of the following questions must be answered for this form to be valid:

1) Can this patient safely be transported by sedan or wheelchair van (that is, seated and secured during transport)? ☐ Yes ☐ No
2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
   To be "bed confined" all three of the following conditions MUST be met: (A) The participant is *unable* to get up from bed without assistance; AND (B) The participant is *unable* to ambulate; AND (C) The participant is *unable* to sit in a chair or wheelchair
3) If not bed confined, reason(s) ambulance service is needed (check all that apply):
4)

☐ Requires continuous O2 monitoring. (see instructions)
☐ Orthopedic Device – Describe:_____
☐ IV Fluids/Meds Required-Med:_____
☐ Cardiac/hemodynamic monitoring required during transport
☐ Decubitus ulcers – Stage & Location:_____
☐ DVT requires elevation of lower extremities
☐ Restraints (physical/chemical) anticipated/used during transport
☐ Bariatric Stretcher Please Explain:_____
☐ Ventilator dependent
☐ Requires airway monitoring/suctioning
☐ Contractures
☐ Other -Describe:_____

<u>SECTION 4 - PROVIDER CERTIFICATION: To be FULLY completed ONLY by a Physician, Physician Assistant, Certified Nurse Practitioner (CRNP), or Dentist</u>

By signing this form, you are certifying:
1. The services described are medically necessary AND
2. You understand that information provided is subject to investigation and verification. Misrepresentation or falsification of essential information which leads to inappropriate payment may lead to sanctions and/or penalties under applicable Federal and/or State law.
3. This form is valid for a period of one year from the date of signing unless the patient's condition warrants recertification or as may be required by the Program.

Check Signee Type: ☐ PHYSICIAN ☐ PHYSICIAN ASSISTANT ☐ CRNP ☐ DENTIST			
Signature of Signee:	Date Signed:	Signee's Medical Assistance Or NPI Number:	
Printed Name of Signee:	Telephone #:	Printed <u>Full</u> Address of Signee:	

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Instructions to Complete the Maryland Statewide Medical Assistance Provider Certification Form

PLEASE PRINT CLEARLY & COMPLETELY – FAILURE TO DO SO WILL RESULT IN DELAYS AS INCOMPLETE AND ILLEGIBLE FORMS MUST BE RETURNED

Section 1 – MUST BE COMPLETED BY PROVIDER

Patient's Name and Address	Enter the patient's Last Name, First Name. A complete and correctly spelled name is crucial for proper patient identification. Enter the patient's home address. If the patient is a resident of an inpatient facility, enter the name and address of the facility along with room and bed number.
Telephone Number	Enter the contact number for the patient (i.e. home telephone or cell number). If patient is a resident of an inpatient facility, enter the inpatient facility telephone number.
Date of Birth, HT & WT	Enter the patient's date of birth as mm/dd/yyyy. Enter height & weight as it's essential for most modes.
Patient's Social Security #	The patient's social security number is optional.
Patient's 11-digit MA #	Enter the patient's 11-digit Medical Assistance number. Do not enter the MCO identification number.
Patient's Medicare #	If applicable, enter the patient's 9-digit Medicare number along with the applicable "letters"
Other Insurance	If applicable, enter other insurance information – ID number and name of other insurance
Environmental Conditions	Enter conditions that apply to the building that the participant is being transported to and from.
Part A Participant	Subsequent to regular screening, verify if requested transport does not qualify for Medicare Part A coverage. If not covered by Medicare and the participant is eligible through screening, schedule the trip.

Section 2 – MUST BE COMPLETED BY PROVIDER

Underlying Medical Diagnosis	DO NOT ENTER ICD code. Spell out primary and secondary diagnosis for which you are providing treatment. Be as comprehensive as possible. What is the underlying medical diagnosis that requires the participant to be transported by ambulance, wheelchair. And why transport by other means is contraindicated by the participant's condition.
Medical Condition	Specify symptoms of the medical condition. Providing this information may support the diagnosis, however, will not justify need for transportation. I.E. "Knee pain" does not medically justify the need for transportation as it is a symptom.
Attendant Required?	Document YES or NO if it is medically necessary for the participant to have someone with them during the transport/for the appointment. If an attendant is required the participant is obligated to provide one, at the discretion of the program, transportation may not be provided without an attendant. Minor children require an attendant.

Section 3 – MUST BE COMPLETED BY PROVIDER

Subsection (a)	Check box for clinically most appropriate mode of transportation. Document the distance of ambulation in feet. Does participant lives within ¾ of a mile from a transit service, are they physically able to utilize either paratransit, the public transit system? Does the participant require Cab/Sedan transportation? If so, the clinical justification for this service must demonstrate the need when other resources are available.
Subsection (b)	Choose only one type of wheelchair. Document the environmental conditions that are applicable to the destination and point of origin. Document the clinical justification why available public transit service is not appropriate.
Subsection (c)	Check the appropriate level and all other applicable information.

Section 4 - Provider's Certification and Signature – MUST BE COMPLETED BY PROVIDER

Signee Type	Check appropriate box. Note only physician, PA, CRNP and dentist are "Authorized" to certify.
Signature of Provider	Signature of signee is mandatory or will be returned which will delay transportation services
Date Signed	Enter actual date signed by provider. This form is valid for a period of one year from the date of signing unless the patient's condition warrants recertification or as may be required by the local health department.
Provider's Medical Assistance or NPI #	Enter Signee's Medical Assistance or NPI #. This number is needed to verify provider's participation in the Medicaid program.
Provider's Telephone #	Enter Signee's telephone number. We may need to contact you.
Provider's Full Address	Enter Signee's full address. We will utilize this to transport the patient for the appointment.

Provider Certification Forms are valid for a period not to exceed one year, subject to changes in patient medical condition affecting mode.
Incomplete forms will be returned to the provider and may delay transportation services.