Instructions to Complete the Out of Area Certification Form

**Section 1- Patient Personal Information – may be completed by patient or provider**

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| 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 residentof 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 number or cell number). Ifpatient is a resident at an inpatient facility, enter the inpatient facility telephone number. |
|  Date of Birth | Enter the patient’s date of birth as mm/dd/yyyy |
|  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 identificationNumber. |
| 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 |

**Section 2 – Referral Information**

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| Name of Facility (if applicable) | Facility where patient is being referred |
| Provider Name | Name of provider to whom patient is being referred |
| Provider Phone | Telephone number of the provider where patient is being referred |
| Complete Physical Address | Address of provider where patient is being referred. Include room/suite/bed number along With zip code. |
| Provider Specialty | Medical discipline of the provider where patient is being referred e.g. Cardiology, Oncologyetc.  |
| Date/Time of Appointment | Time and date of appointment of provider where patient’s is being referred |
| Primary Diagnosis andrelevant secondary diagnosis(es)  | Do not enter ICD or DSM Codes |
| List Relevant AssociatedSymptoms | Symptoms resultant from the above listed diagnoses |

***PLEASE CHECK REASON WHY PATIENT IS BEING SEEN OUT-OF-AREA***

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| Provider Type Check appropriate box. Only Physician, CRNP and Dentist are ‘Authorized” to certify |
| Signature of Provider Signature of provider is mandatory or will be returned which will delay transportation services |
| Date Signed Enter date signed |
| Provider’s Medical Enter referring Provider’s Medical Assistance or NPI #. This number is needed to verify Assistance or NPI # provider’s participation in the Medical Assistance Program  |
| Provider’s Telephone # Enter referring Provider’s telephone number |
| Provider’s Full address Enter referring Provider’s full address. |