**HARFORD COUNTY HEALTH DEPARTMENT**

 **Medical Assistance Transportation Grant Program Phone: (410) 638 - 1671 120 S. Hays Street, P.O. Box 797, Bel Air, Maryland, 21014 FAX: (443) 643-0344**

# STATEWIDE MEDICAL ASSISTANCE PROVIDER CERTIFICATION TO BE COMPLETED FOR ALL OUT OF AREA TRANSPORTS

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

**SECTION 1 - PATIENT PERSONAL INFORMATION:**

|  |  |
| --- | --- |
| Last Name: | First Name: |
| Address: | City/State/Zip: |
| Bldg or Facility Name: | Room/Bed # | Patient Contact/Phone: |
| DOB: | Social Security Number (Optional): |
| Medical AssistanceNumber: | MedicareNumber: | OtherInsurance: |

 **SECTION 2 – REFERRAL INFORMATION:**

|  |
| --- |
| Name of Facility (if applicable): |
| Provider Name: | Provider Phone: |
| Complete Physical Address (including room/suite/bed# if applicable) and zip code: |
| Provider Specialty | Date/Time of Appointment: |
| Primary Diagnosis and Relevant Secondary Diagnosis(es): DO NOT Enter ICD or DSM Codes | List Relevant Associated Symptoms: |

 **MA Transportation is only required to transport to the *CLOSEST* appropriate provider and not necessarily to the one that may be preferred**

Reason patient is being see out-of-area. **Please check one!**

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_\_ | Procedure not available locally | \_\_\_\_\_\_ | No specialist available locally |
| \_\_\_\_\_\_ | Specialist available locally whoparticipates with Medical Assistance, butdoes not participate with client’s MCO | \_\_\_\_\_\_ | Other (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_ | Specialist available locally, but does notparticipate with Medical Assistance/Health Choice |

###  PROVIDER CERTIFICATION: To be completed ONLY by a Physician, Certified Nurse Practitioner (CRNP) or Dentist and must include Medical Assistance or NPI Number

###  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 not to exceed one year from the date of signing.

|  |
| --- |
| Check Provider Type: [ ]  Physician [ ]  CRNP [ ]  Dentist  |
| Signatureof Provider:   | DateSigned: | Provider’s Medical Assistance Or NPI Number: |
| Printed Nameof Provider: | Printed Full Address ofProvider: |
| Provider’s Telephone Number: |