**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 FORM FOR AMBULATORY AND WHEELCHAIR 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 Assistance  Number: | | Medicare  Number: | Other  Insurance: |

**SECTION 2 - PATIENT MEDICAL INFORMATION:**

|  |  |  |
| --- | --- | --- |
| Primary Diagnosis & Relevant Secondary Diagnosis(es):DO NOT enter ICD or DSM Codes | | List Relevant Associated Symptoms: |
|  | |  |
|  | |  |
| Patient Weight  In Pounds: | Patient Height  In Feet & Inches: | Adjunctive Information:  Oxygen  Has own portable tank  Wheeled Cart  Shoulder Bag |
| Other relevant conditions which may affect transport – check only those which apply:  Hearing Impaired  Visually Impaired  Cognitively Impaired  Behavioral or Mental Health Disability | | |

**SECTION 3 - PATIENT MEDICAL TRANSPORT INFORMATION: \* ALL OUT OF AREA TRANSPORTS REQUIRE ADDITIONAL INFORMATION (SEE PAGE 2)**

|  |  |
| --- | --- |
| Type of Medical Service Patient is being Transported for: (List multiple if applicable) | |
|  | |
|  | |
| Duration of Treatment:  Permanent  Temporary | If temporary, anticipated duration: |
| Frequency of Appointments:  Daily  Weekly -­­­­­­ # Times per Week: \_\_\_\_\_\_\_\_\_\_\_\_\_  Monthly -­­­­ # Times per Month: \_\_\_\_\_\_\_\_\_\_\_\_\_  Other: Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**SECTION 4 - CERTIFIED MODE OF TRANSPORTATION:**

1- I certify that this condition/illness causes a temporary or permanent medical need to such a degree that

**it is medically necessary for the individual to be accompanied during transport.**   **Yes  No**

Note: All minors must be accompanied by an adult parent or guardian; however, non-minors require medical necessity to be accompanied during transport.

2- I certify that this condition/illness causes a temporary or permanent medical need to such a degree that

**it is impossible for the patient to use public/ADA/Paratransit transportation.**  **Yes  No**

**CHECK ONE:**

|  |  |
| --- | --- |
| AMBULATORY (Able to walk) Enter Distance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ambulatory means the patient is able to ambulate independently or with assistance. |
| WHEELCHAIR  TRANSFERRABLE  Indicate Type:  REGULAR/MANUAL  ELECTRIC  SCOOTER  XWIDE (Bariatric)  SPECIALTY    Indicate Access at Residence/Pick Up Facility: (if known)  RAMP OR  STEPS If steps, give number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **“WHEELCHAIR”** means the patient is able to travel in a wheelchair and the patient owns or has access to a wheelchair. The Medical Assistance Transportation Office may not have resources to provide wheelchairs and  DOES NOT have resources to return privately owned wheelchairs.  **“TRANSFERRABLE”** means the patient is able to safely transfer from a wheelchair to a vehicle and safely exit the vehicle. |

### 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 | | | |
| Signature  of Provider: | Date  Signed: | | Provider’s Medical  Assistance Or NPI Number: |
| Printed Name  of Provider: | | Printed Full  Address of  Provider: | |
| Provider’s  Telephone Number: | |

Revised 9/30/13