NOT FOR USE FOR HOSPITAL **DISCHARGES/TRANSFERS**

Printed Name of Signee:

Telephone #:

Somerset County Department of Health Medical Assistance Transportation Program LHD Address, PHONE: (443) 523-1700 FAX: (410) 651-1641 MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORTION CERTIFICATION FORM

Last Name:	First N	lame:		Heigh	nt:	Weight:		DOB:	
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 				,		Insura	ance:		
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If Yes, limited transportation benefits r	• ,			nsportatio	on Unit)				
FION 2- List the UNDERLYING MEDICA	DIAGNOSIS and de	escribe the MEDICAL CON	DITION (physical and	l/or menta	I) of this participan	t that requir	res the nartic	rinant to he trans	snorted in
lance, wheelchair or Metro rail/bus/sedan						t triat requir	ics the partie	ipant to be trans	sported iii
nderlying Medical Diagnosis (Do not enter	ICD codes)		Medical Condition	n (Sympto	oms)				
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ION 3 – CHOOSE ONLY ONE CLINIC	ALLY APPROPRIA	TE MODE OF TRANSPO	ORTATION					Oliant many had	
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ilically appropriate for the participant)	•							☐Cab/Sedan	•
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Printed Full 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
Tation o Hamo and Address	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.
	7 9
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

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Check appropriate box. Note only physician, PA, CRNP and dentist are "Authorized" to certify.
Signature of signee is mandatory or will be returned which will delay transportation services
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.
Enter Signee's Medical Assistance or NPI #. This number is needed to verify provider's participation in the
Medicaid program.
Enter Signee's telephone number. We may need to contact you.
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.