Somerset County Department of Health
Medical Assistance Transportation Program
LHD Address PHONE: (443) 523-1700 FAX: (410) 651-1641

MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORTATION TRANSFER/DISCHARGE FORM

SECTION 1 - PATIENT PERSONAL INFORMATION:

Last Name:	First Name:		Height:	Weight:	DOB:
Address:			City/State/Zip:		
Bldg or Facility Name:		Room/Bed #	Patient Contact/Phone:		
Medical Assistance #:	Social Security # (Optional):	Medicare #:		Other Insurance:	

Is this recipient staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ Yes No ☐
(If Yes, Limited Transportation Benefits May Be Available To These Recipients. Please Contact Your Local Health Department MA Transportation Unit)

SECTION 2 –*FACILITY DISCHARGES and TRANSFERS INFORMATION:*

Pick-Up Information		Destination Information	
Facility		Facility	
Address	Zip Code	Address	Zip Code
Room/Suite/Floor		Room/Suite/Floor	
Sending Facility Contact Person	Name:	Phone:	Fax:
Date & Time Requested: Date:	Time:	Authorization #:	

SECTION 3 - MEDICAL DIAGNOSIS and CONDITION List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this participant that requires the recipient 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 or DSM Codes)	Medical Condition (Symptoms)

SECTION 4 – CHOOSE ONLY ONE CLINICALLY APPROPRIATE MODE OF TRANSPORTATION

a) ☐ **AMBULATORY/ABLE TO WALK (with mobility aides)**: Enter distance of ambulation in feet:_____
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** _____

c) ☐ **AMBULANCE - Check Appropriate Level (justify below if other than BLS)** ☐ **BLS** ☐ **ALS** ☐ **SCT/P** ☐ **SCT/N** ☐ **NEO-NATAL**
Clinical Interventions Necessitating Ambulance:_____

Please check building access that is applicable: _____ **RAMP,** _____ **STEPS** If steps, give # _____ **OTHER** _____

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 recipient is *unable* to get up from bed without assistance; AND (B) The recipient is *unable* to ambulate; AND (C) The recipient is *unable* to sit in a chair or wheelchair. ☐ Hospital discharge of wheelchair patient – w/c not sent with patient

3) If not bed confined, reason(s) ambulance service is needed (check all that apply):

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

PSYCH TRANSFERS (if applicable): Circle one →(Voluntary) or (Involuntary): Sedated; [Y] [N] Restrained; [Y] [N] Combative; [Y] [N] Other_____

SECTION 5 - PROVIDER CERTIFICATION: To be FULLY completed by the classifications listed below.

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.

Check **Signee** Type: ☐ PHYSICIAN ☐ PA ☐ CRNP ☐ DISCHARGE NURSE ☐ SOCIAL WORKER		
Signature of **Signee**:	Date Signed:	Treating Provider/Facility Medical Assistance or NPI Number:
Printed Name of **Signee**:	Telephone #:	Printed Full Address of **Signee**:

Revised 7/2018

Instructions to Complete the Maryland Statewide Transfer / Discharge Form

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

Section 1 – PATIENT INFORMATION – must be completed by facility

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, Weight & Height	Enter the patient's date of birth as mm/dd/yyyy. Enter weight & height
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
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 – FACILITY DISCHARGES and TRANSFER INFORMATION

Name of Facility	Enter name and address of facilities, sending and receiving, including floor and room number
Facility Full Address	Enter Facilities full address. We will utilize this to transport the patient for the appointment
Floor / Room Information	Enter floor and room for sending and receiving facility if applicable
Contact Person	Enter name and phone, fax of person program should contact if additional information is required.
Date & Time of Transport	Enter date and time of transport
Authorization	Enter a behavioral health or LHD Authorization number if applicable

Section 3 – MEDICAL DIAGNOSIS and CONDITION

Medical Diagnosis	DO NOT ENTER ICD OR DSM code. Spell out primary and secondary diagnosis for which you are providing treatment. Be as comprehensive as possible.
Medical Condition	Spell out symptoms of the medical condition. Providing this information may support the diagnosis, however, will not provide medical justification for transportation. i.e. "Knee pain" does not medically justify the need for transportation as it is a symptom.

Section 4 – CHOOSE ONLY ONE MODE OF TRANSPORTATION

Indicate type of transportation needed * Ambulatory/Able to Walk * Wheelchair Type * Ambulance	Choose only one (1) certified mode of transportation. Check appropriate box. If wheelchair, check type of wheelchair and indicate applicable condition(s) – ramp, steps w/ #, other. If ambulatory/able to walk, enter distance. If ambulance, check appropriate level. If other than BLS, Indicate applicable condition(s) – ramp, steps with number of steps, other. If the ambulance is needed only due to wheelchair dependency without wheelchair at the hospital, that must be indicated by selecting*: Hospital discharge of wheelchair patient – w/c not sent with patient* If ambulance transport is necessary, questions 1, 2, and 3 MUST be answered, no exceptions.
Psych Transfers	If applicable circle one

Section 5 – PROVIDER CERTIFICATION: To be FULLY completed by the classifications listed below

Signee Type	The **Signee** should check the appropriate box attesting to the information on this form.
Signature	Signature of **signee** is mandatory or will be returned which will delay transportation services.
Date Signed	Enter date signed. 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.
Facility's NPI #	Enter Treating Provider or Facility's NPI #. This number is needed to verify 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.

Incomplete forms will be returned to the Facility and may delay transportation services