Wicomico County Department of Health
Medical Assistance Transportation Program
108 East Main St, Salisbury, MD 21801, PHONE: (667) 977-1050 FAX: (410) 219-2885

MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORT TRANSFER/DISCHARGE FORM

***PLEASE COMPLETE ALL BOXES OR DISCHARGE WILL NOT BE PROCESSED AND WILL DELAY TRANSPORT SERVICES.**

SECTION 1 - PATIENT PERSONAL INFORMATION:

Last Name:	First Name:	Gender: ☐FEMALE ☐MALE	Height:	Weight:	DOB:
Address:		City/State/Zip:			
Building or Facility Name:	Room/Bed #	Patient Contact/Phone:			
Medical Assistance #:	Social Security #:	Medicare #:	Other Insurance:		
Is this participant staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ YES ☐ NO					

SECTION 2 –*FACILITY DISCHARGES and TRANSFERS INFORMATION:*

Pick-Up Information		Destination Information	
Facility		Facility	
Address		Full Address	
Room/Suite/Floor		Room/Suite/Floor	
DISCHARGE Hospital Contact Person	Name:	Phone:	Fax:
Requested **DISCHARGE** Date & Time	Date: _____ Time: _____ or ☐ASAP	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** ☐ **BLS** ☐ **ALS** ☐ **SCT/P** ☐ **SCT/N** ☐ **NEO-NATAL**
(justify below if other than BLS)
Indicate MIEMSS Protocol Justification:(Subject to clinical review): _____

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

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