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 CERTIFICATION FORM

***PLEASE COMPLETE ALL AREAS OR FORM WILL BE DEEMED INCOMPLETE AND TRANPORTATION SERVICES DENIED.**

***Provider Certification Forms are valid for a period of one year, subject to changes in patient medical condition affecting mode.**

SECTION 1 - PATIENT PERSONAL INFORMATION: **EDD:** _____ **NAME OF PCP:** _____

Last Name:	First Name:	Height:	Weight:	DOB:
Parent OR Guardian(s) Name:	Parent OR Guardian(s) DOB:	Gender: ☐ FEMALE ☐ MALE		
Address: City/State/Zip:		Attendant Required? ☐ YES ☐ NO		
Building or Facility Name:	Room/Bed #	Patient Contact/Phone:		
Medical Assistance #:	Social Security #:	Medicare #:	Other Insurance:	

Please check environmental conditions that are applicable: _____ **RAMP,** _____ **STEPS** If steps, give # _____ **OTHER** _____
( ) Destination ( ) Point of Origin

Is this participant staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ YES ☐ NO

SECTION 2- List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this participant that requires the participant 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 CODES)**	Medical Condition (Symptoms)

SECTION 3 – CHOOSE ONLY ONE CLINICALLY APPROPRIATE MODE OF TRANSPORTATION

a) **AMBULATORY/ABLE TO WALK (with mobility aides)** - Enter distance of ambulation in feet:_____
Clinical justification for ambulatory mode of transport: (Justification must include why the public transit system is not clinically appropriate for the participant):
_____

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** _____
( ) Destination ( ) Point of Origin

Clinical justification for wheelchair mode of transport: (Justification must include why the public transit system is not clinically appropriate for the participant):

c) ☐ **AMBULANCE - Check Appropriate Level (justify below if other than BLS)** ☐ **BLS** ☐ **ALS** ☐ **SCT/P** ☐ **SCT/N** ☐ **NEO-NATAL**

Indicate MIEMSS Protocol Justification:(Subject to clinical review): _____

NOTE: Ambulance service will not be provided for the purpose of transferring a participant to a bed or examining table.

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the participant must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is **absolutely** contraindicated by the participant's condition.
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 participant is *unable* to get up from bed without assistance; AND (B) The participant is *unable* to ambulate; AND (C) The participant 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:_____
☐ monitoring/suctioning 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
☐ Contractures
☐ Other -Describe:_____

SECTION 4 - PROVIDER CERTIFICATION: To be FULLY completed ONLY by a Physician, Physician Assistant, Certified Nurse Practitioner (CRNP), or Dentist

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 of one year from the date of signing unless the patient's condition warrants recertification or as may be required by the Program.

Check Signee Type:	☐PHYSICIAN	☐PHYSICIAN ASSISTANT	☐CRNP	☐LCPC	☐LGPC	☐DENTIST
Signature of Signee:		Date Signed:		Signee's Medical Assistance or NPI Number:		
Printed Name of Signee:		Telephone #:		Printed Full Address of Signee:		