Prince George's County Department of Health
Medical Assistance Transportation Program (Not Only For Individual with Disability)
9314 Piscataway Rd, Clinton, MD/ Phone: 301-856-9460 FAX: 301-856-9601/4354/E-Mail: HealthMATP@co.pg.md.us

MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORT CERTIFICATION FORM

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 (If MA# not available):	
Medical Assistance Number:		Medicare Number:	Other Insurance:
Is this recipient staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ Yes ☐ No			

SECTION 2 - MEDICAL DIAGNOSIS / CONDITION List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this recipient 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 recipient's condition: (DO NOT Enter ICD or DSM Codes)

Underlying Medical Diagnosis	Medical Condition (Current Symptoms)
Patient Weight In Pounds:	Patient Height In Feet & Inches:

SECTION 3 – CERTIFY THE NEED FOR MEDICAL TRANSPORTATION:

1) I certify that this condition/illness causes a temporary or permanent medical need to such a degree that **the patient cannot use public/ADA/Paratransit transportation**	☐ **Yes** ☐ **No**
2) 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**

SECTION 4 – CHOOSE ONLY ONE (1) CERTIFIED MODE OF TRANSPORTATION

a) ☐ **AMBULATORY/ABLE TO WALK (with mobility aides)**; Client will be transported by Metrorail/bus/cab/other:
Ambulatory means patient is able to ambulate alone/with assistance. Enter Distance:_____

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

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): _____

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

SECTION 5 - MEDICAL INFORMATION JUSTIFYING AMBULANCE:

NOTE: Ambulance service <u>will not</u> be provided for the transfer of an ambulatory or wheelchair patient 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 recipient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is absolutely contraindicated by the recipient'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 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):

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

SECTION 6 - 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 local health dept.

Check SigneeType: ☐ PHYSICIAN ☐ PHYSICIAN ASSISTANT ☐ CRNP ☐ DENTIST		
Signature of Provider:	Date Signed:	Provider's Medical Assistance Or NPI Number:
Printed Name of Provider:		Printed <u>Full</u> Address of Provider:
Provider's Telephone Number:		

Revised 4/12/2016

Instructions to Complete the Maryland Statewide Medical Assistance Provider Certification Form

Section 1 – Patient Information – 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 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	Enter the patient's date of birth as mm/dd/yyyy.
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 – MUST BE COMPLETED BY PROVIDER

Underlying 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.
Patient Weight in Pounds	Enter weight in pounds.
Patient Height in Feet & Inches	Enter height in feet and inches.

Section 3 – MUST BE COMPLETED BY PROVIDER

Transit Services	Check appropriate box. If on a transit service line, is it possible for the patient to utilize either public, ADA or paratransit transportation? Contact the transportation office if you need clarification on the type of bus services.
Attendant	Check appropriate box. Is it medically necessary for the patient to have someone with them during the transport/for the appointment? Minor children require an attendant.

Section 4 – MUST BE COMPLETED BY PROVIDER

Type of Transportation Needed * Wheelchair Type * Ambulatory/Able to Walk * 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 MIEMSS protocol justification. Indicate applicable condition(s) – ramp, steps w/#, other.

Section 5 – MUST BE COMPLETED BY PROVIDER

Can Patient be Transported by Sedan or Wheelchair Van	Check **Yes** or **No**
Is the Patient Bed Confined	Review the criteria listed on the form for the definition of "Bed Confined." All 3 criteria must be met. Answer **Yes** or **No** as appropriate.
If Not Bed Confined, Reason(s) Why Ambulance Service is Needed	Check all that apply. Use Other to describe any condition not listed that justifies ambulance transport. **Home oxygen is not an automatic qualifier for ambulance transport.**

Section 6 - Provider's Certification and Signature – MUST BE COMPLETED BY PROVIDER

Provider Type	Check appropriate box. Note only physician, CRNP and dentist are "Authorized" to certify.
Signature of Provider	Signature of provider 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 dept.
Provider's Medical Assistance or NPI #	Enter Provider's Medical Assistance or NPI #. This number is needed to verify provider's participation in the Medicaid program.
Provider's Telephone #	Enter Provider's telephone number. We may need to contact you.
Provider's Full Address	Enter Provider'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.

Rev 4/12/2016

If ambulance transport is requested for a participant in a nursing home who is categorized as Medicare Part A, the following transports are eligible for non emergency medical transportation. Regular screening is still required:

1. The ambulance trip is to the SNF (Skilled Nursing Facility) for admission;
2. The ambulance trip is from the SNF to home;
3. The ambulance trip is to a hospital based or nonhospital based ESRD (End State Renal Disease) Facility along with the return trip to the SNF;
4. The ambulance trip is for the following services:

a) Cardiac catheterization;
b) Computerized axial tomography (CT) scans;
c) Magnetic resonance imaging (MRI);
d) Ambulatory surgery that involves the use of an operating room;
e) Angiography;
f) Lymphatic and venous procedures;
g) Radiology therapy; or
h) Removal, replacement and insertion of PEG tubes.

Rev. 4/12/2016