Prince George's County Department of Health
Medical Assistance Transportation Program
9314 Piscataway Rd, Clinton, MD 20735/PHONE: (301) 856-9460/ FAX: (301) 856-9601/4354/E-Mail: HealthMATP@co.pg.md.us

MARYLAND STATEWIDE TRANSPORTATION 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 PERSONAL INFORMATION:

Last Name:		First Name:	
Address:		City/State/Zip:	
Bldg or Facility Name:	Room/Bed #	Patient Contact/Phone:	
DOB:		Social Security Number (Optional):	
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 –*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:		Value Option/ Authorization #:	

SECTION 3 - 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 (Symptoms)
Patient Weight In Pounds:	Patient Height In Feet & Inches:

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 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**
Indicate MIEMSS Protocol Justification:(Subject to clinical review): _____
Please check conditions that are applicable: _____ **RAMP,** _____ **STEPS** If steps, give # _____ **OTHER** _____

SECTION 5 - MEDICAL INFORMATION JUSTIFYING AMBULANCE:

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 by pre-hospital providers
- ☐ Bariatric Stretcher Please Explain:_____

4) **PSYCH TRANSFERS (if applicable): Circle one →(Voluntary) or (Involuntary): Sedated** ☐ **[Y]** ☐ **[N] Restrained; [Y]** ☐ **[N]** ☐ **Combative; [Y]** ☐ **[N]** ☐ **Other**_____

SECTION 6 - 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	☐ DISCHARGE PLANNER
Signature of Provider:		Date Signed:		Provider's Medical Assistance Or NPI Number:	
Printed Name of Provider:		Printed Full Address of Provider:			

Instructions to Complete the Maryland Statewide Transfer / Discharge Form

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	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

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 Value Options / LHD Authorization number if applicable

Section 3

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 4

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

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
Psych Transfers	If applicable circle one

Section 6 - Transportation Certification and Signature

Professional Type	Check appropriate box.
Signature	Signature of Facility 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.
Facility's NPI #	Enter Facility's NPI #. This number is needed to verify Facility'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.

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

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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 Skilled Nursing Facility (SNF)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.

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