



**Harford County Health Department**  
**Medical Assistance Transportation Grant Program**  
 120 S. Hays Street, P.O. Box 797, Bel Air, Maryland 21014  
 Phone: (410)638-1671 FAX: (443)643-0344



**STATEWIDE MEDICAL ASSISTANCE PROVIDER CERTIFICATION TO BE COMPLETED FOR ALL OUT OF AREA TRANSPORTS**

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:	

**SECTION 2 - REFERRAL INFORMATION:**

Name of Facility (if applicable):	
Provider Name:	Provider Phone:
Complete Physical Address (including room/suite/bed# if applicable) and zip code:	
Provider Specialty	Date/Time of Appointment:
Primary Diagnosis and Relevant Secondary Diagnosis(es): DO NOT Enter ICD or DSM Codes	List Relevant Associated Symptoms:

**MA Transportation is only required to transport to the CLOSEST appropriate provider and not necessarily to the one that may be preferred**

Reason patient is being see out-of-area. Please check one!

- |  |  |
|--|--|
| <input type="checkbox"/> Procedure not available locally   | <input type="checkbox"/> No specialist available locally |
| <input type="checkbox"/> Specialist available locally who participates with Medical Assistance, but does not participate with client's MCO | <input type="checkbox"/> Other (explain) _____<br>_____  |
| <input type="checkbox"/> Specialist available locally, but does not participate with Medical Assistance/ Health Choice                     | _____  |

**PROVIDER CERTIFICATION: To be completed ONLY by a Physician, Certified Nurse Practitioner (CRNP) or Dentist and must include Medical Assistance or NPI Number signing this form, you are certifying:**

- The services described are medically necessary AND
- 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.
- This form is valid for a period not to exceed one year from the date of signing.

Check Provider Type: <input type="checkbox"/> Physician <input type="checkbox"/> CRNP <input type="checkbox"/> 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:		

**INFORMATION HELPS PROVIDE ACCURACY OF TRIP. FINAL ARRANGEMENTS MUST BE MADE DIRECTLY BY CLIENT.**