



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 FORM FOR **AMBULATORY AND WHEELCHAIR 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 - PATIENT MEDICAL INFORMATION:

Primary Diagnosis & Relevant Secondary Diagnosis(es):DO NOT enter ICD or DSM Codes		List Relevant Associated Symptoms:	
Patient Weight In Pounds:	Patient Height In Feet & Inches:	Adjunctive Information: <input type="checkbox"/> Oxygen <input type="checkbox"/> Has own portable tank <input type="checkbox"/> Wheeled Cart <input type="checkbox"/> Shoulder Bag	
Other relevant conditions which may affect transport – check only those which apply: <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Cognitively Impaired <input type="checkbox"/> Behavioral or Mental Health Disability			

SECTION 3 - PATIENT MEDICAL TRANSPORT INFORMATION: * ALL OUT OF AREA TRANSPORTS REQUIRE ADDITIONAL INFORMATION (SEE PAGE 2)

Type of Medical Service Patient is being Transported for: (List multiple if applicable)	
Duration of Treatment: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	If temporary, anticipated duration:
Frequency of Appointments: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly - # Times per Week: _____ <input type="checkbox"/> Monthly - # Times per Month: _____ <input type="checkbox"/> Other: Specify: _____	

SECTION 4 - CERTIFIED MODE OF TRANSPORTATION:

1- 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

Note: All minors must be accompanied by an adult parent or guardian; however, non-minors require medical necessity to be accompanied during transport.

2- I certify that this condition/illness causes a temporary or permanent medical need to such a degree that **it is impossible for the patient to use public/ADA/Paratransit transportation.** Yes No

CHECK ONE:

<input type="checkbox"/> AMBULATORY (Able to walk) Enter Distance: _____	Ambulatory means the patient is able to ambulate independently or with assistance.
<input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> TRANSFERRABLE Indicate Type: <input type="checkbox"/> REGULAR/MANUAL <input type="checkbox"/> ELECTRIC <input type="checkbox"/> SCOOTER <input type="checkbox"/> XWIDE (Bariatric) <input type="checkbox"/> SPECIALTY Indicate Access at Residence/Pick Up Facility: (if known) <input type="checkbox"/> RAMP OR <input type="checkbox"/> STEPS If steps, give number _____	<p>"WHEELCHAIR" means the patient is able to travel in a wheelchair and the patient owns or has access to a wheelchair. The Medical Assistance Transportation Office may not have resources to provide wheelchairs and DOES NOT have resources to return privately owned wheelchairs.</p> <p>"TRANSFERRABLE" means the patient is able to safely transfer from a wheelchair to a vehicle and safely exit the vehicle.</p>

PROVIDER CERTIFICATION: To be completed ONLY by a Physician, Certified Nurse Practitioner (CRNP) or Dentist and must include Medical Assistance or NPI Number

By 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 Full Address of Provider:	
Provider's Telephone Number:		