

**Baltimore County Department of Health
Medical Assistance Transportation Grant Program
6401 York Road, Baltimore, Maryland 21212**

Phone: (410) 887-2828
FAX: (410) 377-8296

MARYLAND STATEWIDE MEDICAL ASSISTANCE PROVIDER CERTIFICATION FOR 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 #:	Medicare #:	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 seen 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) _____
_____ |
| <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

By signing this form, you are certifying:

- The services described are medically necessary AND unavailable at a closer facility 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"/> PA	<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:				

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INFORMATION HELPS PROVIDE ACCURACY OF TRIP. FINAL ARRANGEMENTS MUST BE MADE DIRECTLY BY CLIENT
NOT FOR USE FOR HOSPITAL DISCHARGES /TRANSFERS