Instructions to Complete the Statewide Provider Certification Form for Ambulatory and Wheelchair Transports

Section 1 – Patient Information – may be completed by patient or 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

Section 2 – MUST BE COMPLETED BY PROVIDER

Primary and Secondary 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.
Associated Symptoms	Spell out symptoms of the 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.
Weight and Height	Enter weight in pounds and height in feet and inches.
Adjunctive Information	If applicable, check appropriate box
Other Relative Conditions	If applicable, check all that apply.

Section 3 – MUST BE COMPLETED BY PROVIDER

Type of Medical Service	Enter the type(s) of medical service the patient is being transported for.
Duration of Treatment	Check appropriate box. If temporary, complete anticipated duration
Frequency of Appointments	Check appropriate box. If other, specify. Frequency of appointments scheduled helps determine eligibility of Medicaid transportation services.

Section 4 – MUST BE COMPLETED BY PROVIDER

Attendant	Check appropriate box. Is it medically necessary for the patient to have someone with them during the transport/for the appointment?
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 types of bus service.
Type of Transportation Needed (Ambulatory/Wheelchair)	Check appropriate box. If ambulatory, enter distance if ability to ambulate is limited. If wheelchair, can patient transfer? Check type of wheelchair, i.e. regular, electric, etc. Check appropriate box for accessibility. Indicate number of steps, if applicable.

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.
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.

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

Charles County Department of Planning & Growth Management
Transit Division
Medical Assistance Transportation Grant Program
P.O. Box 2150 La Plata, MD 20646
Phone: 301-645-0642
Fax: 301-934-0107

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: ☐ Oxygen ☐ Has own portable tank ☐ Wheeled Cart ☐ Shoulder Bag

Other relevant conditions which may affect transport – check only those which apply:

☐ Hearing Impaired ☐ Visually Impaired ☐ Cognitively Impaired ☐ 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: ☐ Permanent ☐ Temporary	If temporary, anticipated duration:

Frequency of Appointments:

☐ Daily ☐ Weekly - # Times per Week: _____ ☐ Monthly - # Times per Month: _____ ☐ 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:

☐ AMBULATORY (Able to walk) Enter Distance: _____	Ambulatory means the patient is able to ambulate independently or with assistance.
☐ WHEELCHAIR ☐ TRANSFERRABLE Indicate Type: ☐ REGULAR/MANUAL ☐ ELECTRIC ☐ SCOOTER ☐ XWIDE (Bariatric) ☐ SPECIALTY Indicate Access at Residence/Pick Up Facility: (if known) ☐ RAMP OR ☐ STEPS If steps, give number _____	"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. "TRANSFERRABLE" means the patient is able to safely transfer from a wheelchair to a vehicle and safely exit the vehicle.

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:

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 not to exceed one year from the date of signing.

Check Provider Type:	☐ Physician	☐ CRNP	☐ 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:			