REQUEST FOR AUTHORIZATION

(Authorization numbers will be given within (24) hours of request)

Facility/Transportation Provider: _____

Contact Name: _____ **Date:** _____

Phone Number: _____ **Fax Number:** _____

Is the recipient's stay at the facility being reimbursed by Medicare? (Check one) ☐ **YES** ☐ **NO**

Does the visiting doctor participate in the Maryland Medicaid Program? (Check one) ☐ **YES** ☐ **NO**

GENERAL PATIENT INFORMATION

11-DIGIT MEDICAID ASSISTANCE NUMBER (MA#) (REQUIRED): _____

Last Name: _____ **First Name:** _____

Address (Including Zip Code): _____

Phone Number: _____ **DOB:** _____

Is client Ambulatory? (Check one) ☐ **YES** ☐ **NO** **Does Facility provide any form of transportation? (Check one)** ☐ **YES** ☐ **NO**

If "YES", please describe transportation: _____

ORIGIN

Home/Facility Name: _____ **Phone Number:** _____

Address (Including Zip Code): _____

Purpose of trip: _____

If trip is NOT for a doctor's appointment, explain: _____

Date(s) of service: _____

Mode of transportation required: (Check one) ☐ **Ambulance** ☐ **Stretcher** ☐ **Wheelchair Van** ☐ **Geri Chair**

DESTINATION

Physician/Facility Name: _____

Address (Including Zip Code): _____

Phone Number: _____ **Specialty:** _____

MONTGOMERY COUNTY DEPARTMENT OF TRANSPORTATION
DIVISION OF TRANSIT SERVICES
ENHANCED MOBILITY AND SENIOR SERVICES SECTION
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ROCKVILLE, MD 20850
PHONE NUMBER: (240) 777-5890 FAX NUMBER: (240) 777-5891
medicaidtransportation@montgomerycountymd.gov