**Montgomery County Department of Transportation**
**Medical Assistance Transportation Program, Maryland**
**101 Monroe Street, 5th Floor, Rockville, Maryland 20850-2540, PHONE: 240/777-5890, FAX: 240/777-5891**

## 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!**

_____ Procedure not available locally

_____ Specialist available locally who participates with Medical Assistance, but does not participate with client's MCO

_____ Specialist available locally, but does not participate with Medical Assistance/ Health Choice

_____ No specialist available locally

_____ Other (explain)_____

_____

_____

_____

**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: | | | |

**Section 1- Patient Personal 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 number or cell number). If patient is a resident at 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 – Referral Information**

| | |
|---|---|
| Name of Facility (if applicable) | Facility where patient is being referred |
| Provider Name | Name of provider to whom patient is being referred |
| Provider Phone | Telephone number of the provider where patient is being referred |
| Complete Physical Address | Address of provider where patient is being referred. Include room/suite/bed number along With zip code. |
| Provider Specialty | Medical discipline of the provider where patient is being referred e.g. Cardiology, Oncology etc. |
| Date/Time of Appointment | Time and date of appointment of provider where patient's is being referred |
| Primary Diagnosis and relevant secondary diagnosis(es) | Do not enter ICD or DSM Codes |
| List Relevant Associated Symptoms | Symptoms resultant from the above listed diagnoses |

***PLEASE CHECK REASON WHY PATIENT IS BEING SEEN OUT-OF-AREA***

| | |
|---|---|
| Provider Type | Check appropriate box. 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 |
| Provider's Medical Assistance or NPI # | Enter referring Provider's Medical Assistance or NPI #. This number is needed to verify provider's participation in the Medical Assistance Program |
| Provider's Telephone # | Enter referring Provider's telephone number |
| Provider's Full address | Enter referring Provider's full address. |

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