**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 FORM FOR AMBULANCE TRANSPORTS

**PLEASE PRINT CLEARLY & COMPLETELY – FAILURE TO DO SO WILL RESULT IN DELAYS AS INCOMPLETE AND ILLEGIBLE FORMS MUST BE RETURNED**

| **CONTACT NAME :** | **FACILITY :** | **PHONE# :** | **FAX#** |
|---|---|---|---|

**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: |

Is this recipient staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ Yes ☐ No

***If answer is Yes, STOP here. Patient is NOT qualified for MA transportation until all Skilled Nursing benefits have been exhausted***.

**SECTION 2 - PATIENT MEDICAL INFORMATION:**

**NOTE: Ambulance service <u>will not</u> be provided for the transfer of an ambulatory or wheelchair patient to a bed or examining table**

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the recipient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is absolutely contraindicated by the recipient's condition.
**All of the following questions must be answered for this form to be valid:**

1) List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this recipient that requires the recipient to be transported in an ambulance and why transport by other means is contraindicated by the recipient's condition: (DO NOT Enter ICD or DSM Codes)

| Underlying Medical Diagnosis | Medical Condition |
|---|---|
| | |
| | |
| | |
| Patient Weight In Pounds: | Patient Height In Feet & Inches: |

2) Can this patient safely be transported by sedan or wheelchair van (that is, seated and secured during transport)? ☐ Yes ☐ No
3) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
**To be "bed confined" all three of the following conditions MUST be met: (A) The recipient is *unable* to get up from bed without assistance; AND (B) The recipient is *unable* to ambulate; AND (C) The recipient is *unable* to sit in a chair or wheelchair**
4) If not bed confined, reason(s) ambulance service is needed (check all that apply):

- ☐ Contractures
- ☐ Orthopedic Device – Describe:_____
- ☐ IV Fluids/Meds Required-Med:_____
- ☐ Cardiac/hemodynamic monitoring required during transport
- ☐ Restraints (physical/chemical) anticipated/used during transport
- ☐ Other -Describe:_____
- ☐ Decubitus ulcers – Stage & Location:_____
- ☐ DVT requires elevation of lower extremities
- ☐ Ventilator dependent
- ☐ Requires airway monitoring or suctioning
- ☐ Requires continuous oxygen monitoring by pre-hospital providers
- ☐ ER discharge of wheelchair patient - w/c not sent with pt.

**SECTION 3 – USE OF AMBULANCE FOR TRANSPORT:**

| Pick-Up Information | | Destination Information | |
|---|---|---|---|
| Name of Facility | | Name of Facility | |
| Street Address | Zip Code | Street Address | Zip Code |
| Floor Room/Suite | | Floor Room/Suite | |
| Telephone Number | Date of Service: (If Applicable) | Telephone Number | |

**<u>PROVIDER CERTIFICATION: To be completed ONLY by a Physician or Certified Nurse Practitioner (CRNP) and must include Medical Assistance or NPI Number</u>**

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 90 days from the date of signing, or more frequently as may be required by the local Health Department.

| Check Provider Type: ☐ Physician ☐ CRNP | | |
|---|---|---|
| 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: | | |

**Revised on: 10/30/2013**

Instructions to Complete the Statewide Ambulance Certification Form

**Section 1 – Patient Personal Information**

| | |
|---|---|
| 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 | Contact telephone number for patient, if at home, or for responsible staff person at facility |
| 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 |
| Recipient Covered Under Skilled Nursing Benefit? | Check **Yes** or **No.** Form will be returned if response is not checked. |

**Section 2- Patient Medical Information**

| | |
|---|---|
| List Underlying Medical Diagnosis and Medical Condition | Do Not Enter ICD or DSM Codes. Information supplied will be used to determine the necessity of ambulance transport |
| Can Patient be Transported by Sedan or Wheelchair Van | Check **Yes** or **No** |
| Is the Patient Bed Confined | Review the criteria listed on the form for the definition of "Bed Confined." All 3 criteria must be met. Answer **Yes** or **No** as appropriate. |
| If Not Bed Confined, Reason(s) Why Ambulance Service is Needed | Check all that apply. Use Other to describe any condition not listed that justifies ambulance transport |

**Section 3 – Use of Ambulance for Transport**

| | |
|---|---|
| **Name of Sending Facility** | Where recipient will be picked up |
| Street Address | Provide complete street address |
| Floor /Room/Suite | Recipient's location within the facility |
| Telephone Number | Contact telephone number for responsible staff person at pick-up facility |
| **Name of Receiving Facility** | Where recipient will be delivered |
| Street Address | Provide complete street address |
| Floor/Room/Suite | Specific location in receiving facility where recipient is to be delivered |
| Telephone Number | Contact number for responsible staff person at receiving facility |

**Provider's Certification and Signature**

| | |
|---|---|
| Provider Type | Check appropriate. Only Physician and CRNP 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 # | Used to verify provider's participation in the Medical Assistance Program |
| Provider's Telephone # | Enter Provider's telephone number in the event we need to contact you |
| Provider's Full Address | Enter Provider's full address |

**Form Expiration Dates – Nursing Home and Home Bound Recipients – 90 Days from "Date Signed"**
**Inter-Hospital Transports – Each Trip**

**The Local Transportation Program Reserves the Right to Request a New Certification More Frequently As Deemed Necessary**