

**Somerset County Health Department
Medical Assistance Transportation Referral**

Phone: (443) 523-1722
Fax: (410) 651-5680

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!**

- | | |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <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
- 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"/> CRNP	<input type="checkbox"/> 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:			

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

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