

**Somerset County Health Department
Medical Assistance Transportation Grant Program**

**Phone: (443) 523-1722
FAX: (410) 651-5680**

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, Limited Transportation Benefits May Be Available to These Recipients. Please Contact Your Local Health Dept. MA Transportation Unit			

SECTION 2 - PATIENT MEDICAL INFORMATION:

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

SECTION 3 – USE OF AMBULANCE FOR FACILITY DISCHARGES and TRANSFERS ONLY:

Pick-Up Information		Destination Information	
Name of Facility	Zip Code	Name of Facility	Zip Code
Street Address	Zip Code	Street Address	Zip Code
Floor Room/Suite		Floor Room/Suite	
Telephone Number		Telephone Number	

PROVIDER CERTIFICATION: To be completed ONLY by a Physician or Certified Nurse Practitioner (CRNP) 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 90 days from the date of signing, or more frequently as may be required by the local Health Department.

Check Provider Type: <input type="checkbox"/> Physician <input type="checkbox"/> CRNP	
Signature of Provider:	Provider's Medical Assistance Or NPI Number:
Date Signed:	
Printed Name of Provider:	Printed Full Address of Provider:
Provider's Telephone Number:	