

Somerset County Health Department
Medical Assistance Transportation Grant Program
 8928 Sign Post Road, Suite 2, Westover, Maryland 21871
 Phone: (443) 523-1700 FAX: (410) 651-1641

MARYLAND STATEWIDE MEDICAL ASSISTANCE PROVIDER CERTIFICATION FOR 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 #:	Medicare #:	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 seen out-of-area. **Please check one!**

- | | |
|--|---|
| <p>_____ Procedure not available locally</p> <p>_____ Specialist available locally who participates with Medical Assistance, but does not participate with client's MCO</p> <p>_____ Specialist available locally, but does not participate with Medical Assistance/ Health Choice</p> | <p>_____ No specialist available locally</p> <p>_____ Other (explain) _____</p> <p>_____</p> <p>_____</p> |
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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 unavailable at a closer facility 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: <input type="checkbox"/> Physician <input type="checkbox"/> PA <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 <u>Full</u> Address of Provider:	
Provider's Telephone Number:			

Rev 4/2018

INFORMATION HELPS PROVIDE ACCURACY OF TRIP. FINAL ARRANGEMENTS MUST BE MADE DIRECTLY BY CLIENT
NOT FOR USE FOR HOSPITAL DISCHARGES /TRANSFERS