STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Medical Assistance Statewide Provider Certification Form

Patient's 11-digit MA#	**SSN# (Optional):**	**Date of Birth:**
Patient's Name (Last, First, MI)	**Patient's Address**	
Telephone Number	**Patient's Address**	

Destination – must be completed by provider

Name & Address of Office or Clinic **(include bldg name and entrance)**	PCP & Specialty	Telephone Number

1. Mobility aids (check all that apply): Other:_____

__manual/motorized wheelchair __bariatric wheelchair __walker/crutches __braces ____service animal

2. *Diagnosis of recipient's disability (if applicable)* : (do not enter ICD/DSM) must be completed to support medical necessity of mode of transportation indicated in question #4.

_____

Other conditions which may affect transport – circle only those that apply:

__ Hearing Impaired __ Visually Impaired __ Cognitively Impaired __ Morbid Obesity __ Behavioral or Mental Health Disability

If a closer provider is being bypassed, document the medical necessity as to why the recipient cannot be treated by a closer provider:

_____

3. *Symptoms of recipient's disability (i.e. leg pain, headache)*: _____

4. *Circle type of transportation needed*:

Ambulatory	Wheelchair	Stretcher/Ambulance*

*must be medically necessary and/or the patient is bed confined as defined by CMS. Stretcher service may not be used simply to provide manpower to transfer a patient.

Height _____ **Weight** _____ (if available)

5. *Frequency of visits* (indicate number of appointments per week or month):
_____ Weekly _____ Monthly Other: _____

6. *Duration of Treatment*: _____

By signing this form, you are certifying: (*must be signed by a licensed Physician, R.N., L.N.P. or Dentist)

1. That due to the client's condition, he/she is unable to use public transportation (bus or paratransit);
2. The services described are medically necessary and are covered under the Maryland Medicaid Program; and
3. 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.

Physician/Dentist Signature _____ NPI No. _____

Physician/Dentist Name Printed _____ Telephone No. _____

Instructions to Complete the Statewide Provider Certification Form

Patient Information – may be completed by patient or provider

Patient's 11-digit MA#	Enter the patient's 11-digit Medical Assistance number. Do not enter an MCO identification number
Patient's Social Security #	The patient's social security number is optional
Date of Birth	Enter the patient's date of birth as mm/dd/yyyy
Patient's Name and Address	Enter the patient's Last Name, First Name, and Middle Initial. A complete and correctly spelled name is crucial for proper patient identification. Enter the patient's home address. If the patient is a resident in an inpatient facility, enter the address of the facility. Also enter the zip code of the residence.
Telephone Number	Enter an available contact number for the patient (ex: home telephone or cell number) If the patient is a resident in an inpatient facility, enter the address of the facility.

ALL SECTIONS BELOW MUST BE COMPLETED BY THE PROVIDER

Destination(s) – must be completed by provider

Name & Address of Office or Clinic (Include bldg names or entrances)	Enter the name and address of the destination office or clinic. Be sure to include the name of the building, if available, and entrance name.
PCP & Specialty	Enter the physician's name and specialty or type of care being received. Primary care providers may enter "primary care" or "preventive care". For specialty care providers or specialty care referrals, enter the specialty provided. For hospital discharges or transfers, enter "discharge" or "transfer" as appropriate.
Telephone Number	Enter the telephone number of the destination office or clinic

1. Circle any mobility aids that the recipient uses.

2. Diagnosis of recipient's disability – Do not enter the ICD or DSM code to represent the recipient's disability.
   *Provider should spell out the diagnoses, including the primary and secondary conditions for which you are providing treatment or which give rise to the treatment you are providing. Be as comprehensive as possible.
   *If there are other conditions that apply, circle as appropriate.
   *If the recipient does not have a disability, NA or not applicable can be entered.
   *If the recipient is being referred to a provider other than one that is closer to his/her home, it is important to specifically document the medical necessity as to why the recipient cannot be treated by that closer provider.

3. Symptoms of recipient's disability – Spell out the recipient's symptoms of their condition. Providing this information may support the diagnosis, however, will not provide medical justification for Medicaid transportation. For example – "knee pain" does not medically justify the need for transportation as it is a symptom.

4. Type of transportation needed – Choose only one.
   a. Ambulatory – Circle if the patient can ambulate, independently or with assistance.
   b. Wheelchair – Circle this option if the patient is able to safely mobilize a wheelchair or be safely mobilized in a wheelchair by an aide AND the patient owns or has access to a wheelchair.
   c. Stretcher/Ambulance – Circle only if it is medically necessary to transport the patient by stretcher AND the patient meets the CMS definition of "bed-confined".
      Height and weight must be provided.

5. Frequency of visits – Number of appointments per week or month must be entered. Frequency of appointments scheduled helps to determine eligibility of Medicaid transportation.

6. Duration of treatment – Please enter when the recipient's treatment begin and what is the expectation of completion?

Provider's signature and certification

This form must be signed by an authorized provider. An "authorized provider" is a Physician, Dentist, Nurse Practitioner or other provider who is authorized to provide a covered medical service and who has a valid National Provider Identification Number.

This form is valid for a period of one year from the date of signing, except, certification forms for dialysis treatments are valid for dialysis treatment and dialysis-related services indefinitely. Dialysis patients obtaining medical follow-up and/or other medical services, even if related to their kidney disease, must provide an updated Provider's Certification form annually.

This form must completed in full and must contain an original signature. Incomplete forms will be returned to the provider. Forms containing photocopied signatures or signature stamps will be returned to the provider.

This form is required by COMAR 10.09.19.04.A(2) and 10.09.19.07.B