## NOT FOR USE FOR HOSPITAL **DISCHARGES/TRANSFERS**

## **Allegany County Department of Health** Medical Assistance Transportation Program 12501 Willowbrook Rd, Cumberland, MD 21502, PHONE: (301) 759-5123 FAX: (301) 777-2713 MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORTION CERTIFICATION FORM

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

Bidg or Facility       Room/Bed #       Patient Contact/Phone:         Martine       Social Security #       Medical #         Please check environmental conditions that are applicable:       RAMP.       STEPS    Staps, give #       OTHER         I bits participant steping in a Skilled Nursing Facility under a Medicare Part A admission?       () Point of Origin       () Point of Origin         Is this participant steping in a Skilled Nursing Facility under a Medicare Part A admission?       () Point of Origin       () Point of Origin         If Yes, limited transportation benefits may be available. Please contact your Local Health Dept. MA Transportation Unit )       SECTION 2 - CHOOSE ONLY ONG MEDICAL DIA/NOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this participant soundon:       () Participant the participant is participant that requires the participant to be transported in magnetic or Medical Diagnosis (Do not enter ICD codes)       Medical Condition (Symptons)         SECTION 3 - CHOOSE ONLY ONE CLINICALLY APPROPRIATE MODE OF TRANSPORTATION       [] Origin Clinical justification for ambulatory mode of transport: (Justification must include why the public transit system (including paratransit) is not [] Paratransit which clinically appropriate for the participant):       [] Paratransit which clinical system is not clinically appropriate for the participant):         () Destination       () Partit of Origin       () Partit of Origin       OTHER         () Destination       () Partit of Origin       () Partit of Origin       OTHER	SECTION 1 - PATIENT PERSONAL INFORMATION										
Bidg or Facility         RoomBed #         Pellent Contact/Phone:           Medical         Social Security #         Medical end:         Other           Assistance #:         (f1M4r nd exalable):         PLAN         Other           Is this participant staying in a Sulled Nutring Facility under Address Prit A datissch?         I Steps (f1 Address Prit					Height:		W				
Name:         Medical         Stocial Security #         Medical (Medical Assistance #:         Other           Please check environmental conditions that are applicable:         RAMP.         STEPS If steps, give #         OTHER           Is this participant saying in a Skilled Mursing Exclution under a Medicare Part Admission?         I > No         (I / Point of Crigin           Is this participant saying in a Skilled Mursing Exclution under a Medicare Part Admission?         I > No         (I / Point of Crigin           SECTION 2.         List the UNDERLY ING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or motal) of this participant that requires the participant to be transported to motalized by the participant science of ambudaton (Medical Condition (Symptoms)           SECTION 3.         List the UNDERLY ING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or motal) of this participant to be transported to motalized by the participant's condition.           Section 3.         Check environmental conditions that are applicable:         FRAMP, STEPS If stops give #         Check may transit system (including partransit) is not (including partransit) is not (including partransit) system (including partransit) system (including partransit) system (including partransit) is not (including partransit) i	Address:			City	City/State/Zip:			Attendant Required? YES NO			
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( ) Destination     ( ) Point of Origin     ( ) P	Assistance #: (If MA# not available):			-				Insurance:			
	Please check environmental conditions that are										
ambulance, wheeldhair of Merice allbussedan and why transport by other means is contraindicated by the participant's condition:       Inderking Medical Diagnosis (Do not enter ICD codes)         Inderking Medical Diagnosis (Do not enter ICD codes)       Medical Condition (Symptoms)         section 3 - CHOOSE ONLY ONE CLINICALLY APPROPRIATE MODE OF TRANSPORTATION       Imbulance in the participant is condition:         a) ABBULATORY/ABLE TO WALK (with mobility aldes) - Enter distance of ambulation in feet:       Imbulance in feet:         Cilinical justification for ambulatory mode of transport: (Justification must include why the public transit system (including paratransit) is not       Imbulance in the participant):         b)       WHEELCHAIR Check Type:       REGULAR WIC       ELEC.W/C       ELECTRIC SCOOTER       X-WIDE W/C       SPECIALTY W/C         Please check environmental conditions that are applicable:       RAMP,       STEPS if daps, give #       OTHER       OTHER         Clinical justification for wheelChair mode of transport: (Justification must include why the public transit system is not clinically appropriate for the participant):       Implementary appropriate for the participant is analytic biologic and the them and public why the public transit system is not clinically appropriate for the participant is analytic biologic and the them and unce is abeolutely contraindicated by the participant is analytic biologic and the participant is analytic biologic andit and the participant is analytic and the participant is analytic											
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Clinical Interventions Necessitating Ambulance:         NOTE: Ambulance service will not be provided for the purpose of transferring a participant 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 participant must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is absolutely contraindicated by the participant is condition.         All of the following questions must be answered for this form to be valid: <ul> <li>(a) Can this patient safely be transported by sedan or wheelchair van (that is, seated and secured during transport)?</li> <li>(b) Is this patient 'bed confined' as defined below?</li> <li>(c) Can this patient 'bed confined, reason(s) ambulance service is needed (check all that apply):</li> <li>(c) To be "bed confined, reason(s) ambulance service is needed (check all that apply):</li> <li>(c) Pertrilator dependent</li> <li>(c) Orthopedic Device – Describe:</li> <li>(c) VF requires elevation of lower extremities</li> <li>(c) Cantractures</li> <li>(c) VF luids/Meds Required-Medt:</li> <li>(c) VF luids/Meds Required-Medt:</li> <li>(c) VF luids/Meds Required-Medt:</li> <li>(c) VF luids/Meds Required during transport</li> <li>(c) Barting the form, you are certifying:</li> <li>(c) The services described are medically necessary AND</li> <li>(c) We candid the formation provided is subject to investigation and verification. Misrepresentation or falsification or as may be required by the Program.</li> <li>(Check Signee Type:</li> <li>(c) PHYSICIAN ASSISTANT</li> <li>(c) Requires inder applicable Foderal and/or State law.</li> <li>(c) The services described</li></ul>	Clinical justification for wheelchair mode of transport: (Justification must include why the public transit system is not clinically appropriate for the participant):										
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Printed Name of Signee:     Telephone #:     Printed Full Address of Signee:	Signature of Signee:			Date Signed	Signed: Signee's Medical Assistar			istance Or NPI N	ance Or NPI Number:		
	Printed Name of Signee: Te		Printed <u>Full</u> Address of Signee:								