HARFORD COUNTY HEALTH DEPARTMENT
Medical Assistance Transportation Grant Program
120 S. Hays Street, P.O. Box 797, Bel Air, Maryland, 21014
Phone: (410) 638 - 1671
FAX: (443) 643-0344

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!**

_____ Procedure not available locally

_____ Specialist available locally who participates with Medical Assistance, but does not participate with client's MCO

_____ Specialist available locally, but does not participate with Medical Assistance/ Health Choice

_____ No specialist available locally

_____ Other (explain)_____

_____

_____

_____

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
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: ☐ Physician		☐ CRNP	☐ 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