Public Health
Prevent. Promote. Protect.
Harford County
Health Department

Instructions to Complete the Statewide Ambulance Certification Form

Section 1 – Patient Personal Information

Patient's Name and Address	Enter the patient's Last Name, First Name. A complete and correctly spelled name is crucial for proper patient identification. Enter the patient's home address. If the patient is a resident of an inpatient facility, enter the name and address of the facility along with room and bed number.
Telephone Number	Contact telephone number for patient, if at home, or for responsible staff person at facility
Date of Birth	Enter the patient's date of birth as mm/dd/yyyy.
Patient's Social Security #	The patient's social security number is optional.
Patient's 11-digit MA #	Enter the patient's 11-digit Medical Assistance number. Do not enter the MCO identification number.
Patient's Medicare #	If applicable, enter the patient's 9-digit Medicare number along with the applicable "letters"
Other Insurance	If applicable, enter other insurance information – ID number and name of other insurance
Recipient Covered Under Skilled Nursing Benefit?	Check **Yes** or **No.** Form will be returned if response is not checked.

Section 2- Patient Medical Information

List Underlying Medical Diagnosis and Medical Condition	Do Not Enter ICD or DSM Codes. Information supplied will be used to determine the necessity of ambulance transport
Can Patient be Transported by Sedan or Wheelchair Van	Check **Yes** or **No**
Is the Patient Bed Confined	Review the criteria listed on the form for the definition of "Bed Confined." All 3 criteria must be met. Answer **Yes** or **No** as appropriate.
If Not Bed Confined, Reason(s) Why Ambulance Service is Needed	Check all that apply. Use Other to describe any condition not listed that justifies ambulance transport

Section 3 – Use of Ambulance for Facility Discharges and Transfers

Name of Sending Facility	Where recipient will be picked up
Street Address	Provide complete street address
Floor /Room/Suite	Recipient's location within the facility
Telephone Number	Contact telephone number for responsible staff person at pick-up facility
Name of Receiving Facility	Where recipient will be delivered
Street Address	Provide complete street address
Floor/Room/Suite	Specific location in receiving facility where recipient is to be delivered
Telephone Number	Contact number for responsible staff person at receiving facility

Provider's Certification and Signature

Provider Type	Check appropriate. Only Physician and CRNP are "Authorized" to certify
Signature of Provider	Signature of provider is mandatory or will be returned which will delay transportation services
Date Signed	Enter date signed
Provider's Medical Assistance Or NPI #	Used to verify provider's participation in the Medical Assistance Program
Provider's Telephone #	Enter Provider's telephone number in the event we need to contact you
Provider's Full Address	Enter Provider's full address

Form Expiration Dates – Nursing Home and Home Bound Recipients – 90 Days from "Date Signed"

- **Inter-Hospital Transports – Each Trip**

The Local Transportation Program Reserves the Right to Request a New Certification More Frequently As Deemed Necessary