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

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 FORM FOR AMBULATORY AND WHEELCHAIR 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 - PATIENT MEDICAL INFORMATION:

Primary Diagnosis & Relevant Secondary Diagnosis(es):DO NOT enter ICD or DSM Codes		List Relevant Associated Symptoms:
Patient Weight In Pounds:	Patient Height In Feet & Inches:	Adjunctive Information: ☐ Oxygen ☐ Has own portable tank ☐ Wheeled Cart ☐ Shoulder Bag
Other relevant conditions which may affect transport – check only those which apply: ☐ Hearing Impaired ☐ Visually Impaired ☐ Cognitively Impaired ☐ Behavioral or Mental Health Disability		

SECTION 3 - PATIENT MEDICAL TRANSPORT INFORMATION: * ALL OUT OF AREA TRANSPORTS REQUIRE ADDITIONAL INFORMATION (SEE PAGE 2)

Type of Medical Service Patient is being Transported for: (List multiple if applicable)	
Duration of Treatment: ☐ Permanent ☐ Temporary	If temporary, anticipated duration:
Frequency of Appointments: ☐ Daily ☐ Weekly - # Times per Week: _____ ☐ Monthly - # Times per Month: _____ ☐ Other: Specify: _____	

SECTION 4 - CERTIFIED MODE OF TRANSPORTATION:

1- I certify that this condition/illness causes a temporary or permanent medical need to such a degree that **it is medically necessary for the individual to be accompanied during transport.** ☐ **Yes** ☐ **No**

Note: All minors must be accompanied by an adult parent or guardian; however, non-minors require medical necessity to be accompanied during transport.

2- I certify that this condition/illness causes a temporary or permanent medical need to such a degree that **it is impossible for the patient to use public/ADA/Paratransit transportation.** ☐ **Yes** ☐ **No**

CHECK ONE:

☐ AMBULATORY (Able to walk) Enter Distance: _____	Ambulatory means the patient is able to ambulate independently or with assistance.
☐ WHEELCHAIR ☐ TRANSFERRABLE Indicate Type: ☐ REGULAR/MANUAL ☐ ELECTRIC ☐ SCOOTER ☐ XWIDE (Bariatric) ☐ SPECIALTY Indicate Access at Residence/Pick Up Facility: (if known) ☐ RAMP OR ☐ STEPS If steps, give number _____	**"WHEELCHAIR"** means the patient is able to travel in a wheelchair and the patient owns or has access to a wheelchair. The Medical Assistance Transportation Office may not have resources to provide wheelchairs and DOES NOT have resources to return privately owned wheelchairs. **"TRANSFERRABLE"** means the patient is able to safely transfer from a wheelchair to a vehicle and safely exit the vehicle.

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:		