



BALTIMORE CITY HEALTH DEPARTMENT

FIELD HEALTH SERVICES

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Funded By a Grant From:



STATE OF MARYLAND  
Office of Health Services  
Medical Care Programs  
DMH  
Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Statewide Provider Certification for Maryland Medical Assistance Transportation

Form with fields for Patient's 11-digit Md. MA #, Patient's Name, Patient's Street Address, Name of Building/Facility, Social Security Number (optional), Date of Birth, Telephone Number, Zip Code, and Apt / Room #.

Primary Destination(s):

Form with three columns: Name & Address of Office or Clinic, Type of Medical Service to be Obtained, and Duration Svc Will Be Needed.

Primary Diagnosis and Relevant Secondary Diagnosis(es):

Form with instructions to spell out diagnoses and checkboxes for conditions like hearing impaired, visually impaired, etc.

Type of Transportation Needed:

Form with checkboxes for Ambulatory, Wheelchair, Stretcher, and detailed descriptions of each service type.

Adjunctive Services Needed (indicate ONLY those which apply):

Form with checkboxes for Oxygen, I.V. Access, Isolation Precautions, and other medical services.

Provider Certification – by signing this form, you are certifying:

- 1. The services described are medically necessary and are covered services under the Maryland Medicaid Program.
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.

Form for provider signature and printed information including Name of Provider, Address of Provider, and Telephone Number.

PLEASE BE SURE FORM THIS FORM IS COMPLETE and LEGIBLE! INCOMPLETE or ILLEGIBLE FORMS WILL BE RETURNED.

# INSTRUCTIONS

**Patient Demographics** – may be completed by patient or provider.

Patient's 11-digit Md MA #	Insert the patient's 11-digit Medical Assistance Number. Do not insert an MCO identification number.
Patient's Social Security #	Social Security number is optional, but may help identify a patient if an error is made in the MA number.
Patient's Name (Last, First, MI)	Enter the patient's Last Name, First Name, and MIDDLE NAME or INITIAL. If the patient has no middle name, enter "NMI". <b>Note:</b> A complete name is crucial for proper patient identification.
Date of Birth	Enter patient's date of birth as mm/dd/yyyy
Patient's Street Address	Enter the patient's home address. If the patient is a resident in an inpatient facility, enter the address of the facility.
Telephone Number	Enter the patient's home telephone number. If the patient is a resident in an inpatient facility, enter the telephone number of the facility.
Name of Building/Facility	If the patient lives in a named building (apartment house, etc), enter the name of the building. If the patient is a resident in an inpatient facility, enter the name of the facility.
Zip Code	Enter the Zip Code of the patient's residence.

**Primary Destination(s)** – must be completed by provider

Name & Address of Office or Clinic (Include building names or entrances)	Enter the name of clinic (if any) and the provider's office address. Do not enter the provider's name. Include the name on the outside of the building in which the office is located.
Type of Medical Service to be Obtained	Enter the type of service normally provided in the office identified. 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.
Duration Svc Will Be Needed (Not to exceed one year)	Enter the length of time the patient will require services. Do not enter the length of appointment time. For time-limited services such as physical therapy or radiation/chemotherapy treatment, enter the length of time (in weeks or months) the patient will require treatment. Do not enter the number of treatments required. For hospital discharges or transfers, enter "one time". For dialysis treatment only, providers may enter "indefinitely".

**Primary Diagnosis and Relevant Secondary Diagnosis(es)** – must be completed by provider

Spell out diagnoses – DO NOT enter ICD or DSM codes	Enter 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. Do not code. Commonly accepted medical abbreviations are acceptable.
Need for an aide	Check only one – always, sometimes, or never. Please note: the Medical Assistance Transportation Office does not provide aides.
Ability to use public transportation	Check only one – always, sometimes, or never.
Other conditions which may affect transport	Check only those which apply. If none of the listed conditions apply, leave blank.

**Type of Transportation Needed** – must be completed by provider. Choose only one.

Ambulatory	Check this section if the patient can ambulate, independently or with assistance.
Wheelchair	Check this section 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. Check "Transferrable" if the patient is able to safely transfer from the wheelchair to a vehicle and safely transfer from the vehicle to a wheelchair.
Stretcher	Check this section <b>ONLY IF</b> it is medically necessary to transport the patient by stretcher AND the patient meets the CMS definition of "bed-confined". All information requested in this section must be provided: patient weight and number of steps inside and outside the patient's residence.

<b>Adjunctive Services Needed</b> must be completed by provider	Check <b>ONLY</b> those which apply, and check <b>ALL</b> which apply. For any service block checked, provide all requested information. If inapplicable, leave blank. Do not enter "n/a".
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**Provider Certification** – must be completed by provider.

This form must be signed by an authorized provider. An "authorized provider" is a Physician, Nurse Practitioner, or other provider who is providing a covered medical service **and** who has a valid Medical Assistance Provider Number or National Provider Identification Number **and** who is billing Medical Assistance for the service rendered.

This form is valid for a period of one year from the date of signing, except that certification forms for dialysis treatment 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 be 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)**

*A downloadable copy of this form is available at: <http://www.baltimorehealth.org/transportation.html>*