Baltimore City Department of Health
Medical Assistance Transportation Grant Program **Phone: (410) 396-7633**
1200 E. Fayette Street, 2nd Floor Suite 230, Baltimore, Maryland 21202 **FAX: (410) 545-3011**

MARYLAND STATEWIDE MEDICAL ASSISTANCE PROVIDER CERTIFICATION FOR 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 #:		Medicare #:	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 seen out-of-area. **Please check one!**

______ Procedure not available locally

______ No specialist available locally

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

______ Other (explain)____

____

____

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

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 unavailable at a closer facility 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 ☐ PA ☐ 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:		

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INFORMATION HELPS PROVIDE ACCURACY OF TRIP. FINAL ARRANGEMENTS MUST BE MADE DIRECTLY BY CLIENT

NOT FOR USE FOR HOSPITAL DISCHARGES /TRANSFERS

Instructions to Complete the Out of Area Certification Form

Section 1- Patient Personal Information – may be completed by patient or provider

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	Enter the contact number for the patient (i.e. home telephone number or cell number). If patient is a resident at an inpatient facility, enter the inpatient facility telephone number.
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

Section 2 – Referral Information

Name of Facility (if applicable)	Facility where patient is being referred
Provider Name	Name of provider to whom patient is being referred
Provider Phone	Telephone number of the provider where patient is being referred
Complete Physical Address	Address of provider where patient is being referred. Include room/suite/bed number along With zip code.
Provider Specialty	Medical discipline of the provider where patient is being referred e.g. cardiology, oncology etc.
Date/Time of Appointment	Time and date of appointment of provider where patient's is being referred
Primary Diagnosis and relevant secondary diagnosis(es)	Do not enter ICD or DSM Codes
List Relevant Associated Symptoms	Symptoms resultant from the above listed diagnoses

PLEASE CHECK REASON WHY PATIENT IS BEING SEEN OUT-OF-AREA

Provider Type	Check appropriate box. Only physician, physician assistant, CRNP and dentist 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 #	Enter referring Provider's Medical Assistance or NPI #. This number is needed to verify provider's participation in the Medical Assistance Program
Provider's Telephone #	Enter referring Provider's telephone number
Provider's Full Address	Enter referring Provider's full address.

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