Baltimore **City** Department of Health
Medical Assistance Transportation Grant Program
211 East 25th Street Baltimore, Maryland 2121**8**
Phone: (410) **396-6422**
FAX: (410) **545-3011**

STATEWIDE MEDICAL ASSISTANCE PROVIDER CERTIFICATION FORM FOR AMBULANCE 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:

Is this recipient staying in a Skilled Nursing Facility under a Medicare Part A admission? ☐ Yes ☐ No

If Yes, Limited Transportation Benefits May Be Available to These Recipients. Please Contact Your Local Health Dept. MA Transportation Unit

SECTION 2 - PATIENT MEDICAL INFORMATION:

NOTE: Ambulance service will not be provided for the transfer of an ambulatory or wheelchair patient to a bed or examining table

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the recipient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is absolutely contraindicated by the recipient's condition.
All of the following questions must be answered for this form to be valid:

1) List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this recipient that requires the recipient to be transported in an ambulance and why transport by other means is contraindicated by the recipient's condition: (DO NOT Enter ICD or DSM Codes)

Underlying Medical Diagnosis	Medical Condition
Patient Weight In Pounds:	Patient Height In Feet & Inches:

2) Can this patient safely be transported by sedan or wheelchair van (that is, seated and secured during transport)? ☐ Yes ☐ No
3) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
To be "bed confined" all three of the following conditions MUST be met: (A) The recipient is *unable* to get up from bed without assistance; AND (B) The recipient is *unable* to ambulate; AND (C) The recipient is *unable* to sit in a chair or wheelchair
4) If not bed confined, reason(s) ambulance service is needed (check all that apply):

- ☐ Contractures
- ☐ Orthopedic Device – Describe:_____
- ☐ IV Fluids/Meds Required-Med:_____
- ☐ Cardiac/hemodynamic monitoring required during transport
- ☐ Restraints (physical/chemical) anticipated/used during transport
- ☐ Other -Describe:_____
- ☐ Decubitus ulcers – Stage & Location:_____
- ☐ DVT requires elevation of lower extremities
- ☐ Ventilator dependent
- ☐ Requires airway monitoring or suctioning
- ☐ Requires continuous oxygen monitoring by pre-hospital providers
- ☐ ER discharge of wheelchair patient - w/c not sent with pt.

SECTION 3 – USE OF AMBULANCE FOR *FACILITY DISCHARGES and TRANSFERS ONLY*:

Pick-Up Information		Destination Information	
Name of Facility		Name of Facility	
Street Address	Zip Code	Street Address	Zip Code
Floor Room/Suite		Floor Room/Suite	
Telephone Number		Telephone Number	

PROVIDER CERTIFICATION: To be completed ONLY by a Physician, Physician Assistant or Certified Nurse Practitioner (CRNP) 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 90 days from the date of signing, or more frequently as may be required by the local Health Department.

Check Provider Type: ☐ Physician ☐ CRNP ☐ Physician Assistant

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:		