



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!

<input type="checkbox"/> Procedure not available locally	<input type="checkbox"/> No specialist available locally
<input type="checkbox"/> Specialist available locally who participates with Medical Assistance, but does not participate with client's MCO	<input type="checkbox"/> Other (explain) _____
<input type="checkbox"/> 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: <input type="checkbox"/> Physician <input type="checkbox"/> PA <input type="checkbox"/> CRNP <input type="checkbox"/> 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:			

Rev 4/2018

INFORMATION HELPS PROVIDE ACCURACY OF TRIP. FINAL ARRANGEMENTS MUST BE MADE DIRECTLY BY CLIENT
NOT FOR USE FOR HOSPITAL DISCHARGES /TRANSFERS