

Howard County Department of Health Medical Assistance Transportation Program

8930 Stanford Blvd, Columbia, Maryland 21045
 PHONE: 1 (877) 312-5571 FAX: (410) 313-6315

MARYLAND STATEWIDE MEDICAL ASSISTANCE TRANSPORTATION TRANSFER/DISCHARGE FORM

SECTION 1 - PATIENT PERSONAL INFORMATION:

Last Name:	First Name:	Height:	Weight:	DOB:
Address:		City/State/Zip:		
Bldg or Facility Name:	Room Bed #	Patient Contact/Phone:		
Medical Assistance #:	Social Security # (Optional):	Medicare #:	Other Insurance:	
Is this recipient staying in a Skilled Nursing Facility under a Medicare Part A admission? <input type="checkbox"/> Yes No <input type="checkbox"/>				
(If Yes, Limited Transportation Benefits May Be Available To These Recipients. Please Contact Your Local Health Department MA Transportation Unit)				

SECTION 2 - FACILITY DISCHARGES and TRANSFERS INFORMATION:

Pick-Up Information		Destination Information	
Facility		Facility	
Address	Zip Code	Address	Zip Code
Room/Suite/Floor		Room/Suite/Floor	
Sending Facility Contact Person	Name:	Phone:	Fax:
Date & Time Requested:	Date: Time:	Authorization #:	

SECTION 3 - MEDICAL DIAGNOSIS and CONDITION List the UNDERLYING MEDICAL DIAGNOSIS and describe the MEDICAL CONDITION (physical and/or mental) of this participant that requires the recipient to be transported in ambulance, wheelchair or Metro rail/bus/sedan and why transport by other means is contraindicated by the participant's condition:

Underlying Medical Diagnosis (DO NOT Enter ICD or DSM Codes)	Medical Condition (Symptoms)

SECTION 4 - CHOOSE ONLY ONE CLINICALLY APPROPRIATE MODE OF TRANSPORTATION

a) **AMBULATORY/ABLE TO WALK (with mobility aides):** Enter distance of ambulation in feet: _____
 Client may be transported by: Paratransit vehicle Public transit system Cab/Sedan

b) **WHEELCHAIR** Check Type: REGULAR W/C ELEC. W/C ELECTRIC SCOOTER X-WIDE W/C SPECIALTY W/C
 Please check environmental conditions that are applicable: _____ RAMP, _____ STEPS If steps, give # _____ OTHER _____

c) **AMBULANCE - Check Appropriate Level (justify below if other than BLS)** BLS ALS SCT/P SCT/N NEO-NATAL

Clinical Interventions Necessitating Ambulance: _____

Please check building access that is applicable: _____ RAMP, _____ STEPS If steps, give # _____ OTHER _____

All of the following questions must be answered for this form to be valid:

1) Can this patient safely be transported by sedan or wheelchair van (that is, seated and secured during transport)? Yes No
 2) 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. Hospital discharge of wheelchair patient - w/c not sent with patient

3) If not bed confined, reason(s) ambulance service is needed (check all that apply):

<input type="checkbox"/> Requires continuous O2 monitoring. (see instructions)	<input type="checkbox"/> Decubitus ulcers - Stage & Location: _____	<input type="checkbox"/> Ventilator dependent
<input type="checkbox"/> Orthopedic Device - Describe: _____	<input type="checkbox"/> DVT requires elevation of lower extremities	<input type="checkbox"/> Requires airway monitoring/suctioning
<input type="checkbox"/> IV Fluids/Meds Required-Med: _____	<input type="checkbox"/> Restraints (physical/chemical) anticipated/used during transport	<input type="checkbox"/> Contractures
<input type="checkbox"/> Cardiac/hemodynamic monitoring required during transport	<input type="checkbox"/> Bariatric Stretcher Please Explain: _____	<input type="checkbox"/> Other -Describe: _____

PSYCH TRANSFERS (if applicable): Circle one →(Voluntary) or (Involuntary): Sedated; [Y] [N] Restrained; [Y] [N] Combative; [Y] [N] Other _____

SECTION 5 - PROVIDER CERTIFICATION: To be FULLY completed by the classifications listed below.

By signing this form, you are certifying:

- The services described are medically necessary AND
- 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.

Check Signee Type: <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PA <input type="checkbox"/> CRNP <input type="checkbox"/> DISCHARGE NURSE <input type="checkbox"/> SOCIAL WORKER
Signature of Signee: _____ Date Signed: _____ Treating Provider/Facility Medical Assistance or NPI Number: _____
Printed Name of Signee: _____ Telephone #: _____ Printed Full Address of Signee: _____