



**Public Health**  
Prevent. Promote. Protect.

**Carroll County Department of Health  
Medical Assistance Transportation Program**

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**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 <input type="checkbox"/> 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 \_\_\_\_\_  
water mark

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; Yes No Restrained; Yes No Combative; Yes No 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: _____

Instructions to Complete the Maryland Statewide Transfer / Discharge Form

PLEASE PRINT CLEARLY & COMPLETELY - FAILURE TO DO SO WILL RESULT IN DELAYS AS INCOMPLETE AND ILLEGIBLE FORMS MUST BE RETURNED

**Section 1 – PATIENT INFORMATION – must be completed by facility**

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 or cell number). If patient is a resident of an inpatient facility, enter the inpatient facility telephone number.
Date of Birth, Weight & Height	Enter the patient's date of birth as mm/dd/yyyy. Enter weight & height
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
Part A Participant	Subsequent to regular screening, verify if requested transport does not qualify for Medicare Part A coverage. If not covered by Medicare and the participant is eligible through screening, schedule the trip.

**Section 2 – FACILITY DISCHARGES and TRANSFER INFORMATION**

Name of Facility	Enter name and address of facilities, sending and receiving, including floor and room number
Facility Full Address	Enter Facilities full address. We will utilize this to transport the patient for the appointment
Floor / Room Information	Enter floor and room for sending and receiving facility if applicable
Contact Person	Enter name and phone, fax of person program should contact if additional information is required.
Date & Time of Transport	Enter date and time of transport
Authorization	Enter a behavioral health or LHD Authorization number if applicable

**Section 3 – MEDICAL DIAGNOSIS and CONDITION**

Medical Diagnosis	DO NOT ENTER ICD OR DSM code. Spell out primary and secondary diagnosis for which you are providing treatment. Be as comprehensive as possible.
Medical Condition	Spell out symptoms of the medical condition. Providing this information may support the diagnosis, however, will not provide medical justification for transportation. i.e. "Knee pain" does not medically justify the need for transportation as it is a symptom.

**Section 4 – CHOOSE ONLY ONE MODE OF TRANSPORTATION**

Indicate type of transportation needed * Ambulatory/Able to Walk * Wheelchair Type * Ambulance	Choose only one (1) certified mode of transportation. Check appropriate box. If wheelchair, check type of wheelchair and indicate applicable condition(s) – ramp, steps w/ #, other. If ambulatory/able to walk, enter distance. If ambulance, check appropriate level. If other than BLS, Indicate applicable condition(s) – ramp, steps with number of steps, other. If the ambulance is needed only due to wheelchair dependency without wheelchair at the hospital, that must be indicated by selecting: <i>Hospital discharge of wheelchair patient – w/c not sent with patient</i> If ambulance transport is necessary, questions 1, 2, and 3 MUST be answered, no exceptions.
Psych Transfers	If applicable circle one

**Section 5 – PROVIDER CERTIFICATION: To be FULLY completed by the classifications listed below**

Signee Type	The Signee should check the appropriate box attesting to the information on this form.
Signature	Signature of signee is mandatory or will be returned which will delay transportation services.
Date Signed	Enter date signed. This form is valid for a period of one year from the date of signing unless the patient's condition warrants recertification or as may be required by the local health department.
Facility's NPI #	Enter Treating Provider or Facility's NPI #. This number is needed to verify participation in the Medicaid program.
Provider's Telephone #	Enter Signee's telephone number. We may need to contact you.
Provider's Full Address	Enter Signee's full address. We will utilize this to transport the patient for the appointment.

Incomplete forms will be returned to the Facility and may delay transportation services