BALTIMORE CITY HEALTH DEPARTMENT
FIELD HEALTH SERVICES
211 East 25th Street
Baltimore, Maryland 21218

Voice # (Business Hours) : (410) 396-7433
Paging # (Nights/Weekends) : (410) 396-5852
Fax Number (all hours) : (410) 889-7560

Funded By a Grant From:

STATE OF MARYLAND DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Statewide Physician Certification for Medical Assistance Air Transportation

Patient's 11-digit MA #		Social Security Number	
Patient's Name (Last, First, MI)		Date of Birth	
Patient's Address		Telephone Number	
Patient's Address		Zip Code	
PreAuthorization # (if obtained)			

Transfer Information (***PLEASE PRINT LEGIBLY***):

Sending Facility		Accepting Facility	
Name of Hospital		Name of Hospital	
Address of Hospital		Address of Hospital	
Referring Department		Accepting Department	
Referring Physician		Accepting Physician	

Primary Diagnosis and Reason for Transfer (***PLEASE PRINT LEGIBLY***):

SENDING PHYSICIAN PLEASE NOTE: Items left blank are presumed to be answered "no".

Diagnosis

Resources Needed
❑ PICU ❑ TRAUMA – Level ______ ❑ Other (specify)
❑ NICU ❑ PERINATAL/NEONATAL – Level ______

❑ Yes ❑ No — Is this resource available at the sending facility?

❑ Yes ❑ No — Is the patient being transferred to the closest facility which has this resource?
If not, why not
(If on bypass, so indicate):

❑ Yes ❑ No — Is the patient UNSTABLE?

Level of Service Required
❑ BLS ❑ SPECIALTY CARE ("Specialty Care" means the patient is vented, or requires medication or specialty skills outside the local EMS protocols.)
❑ ALS ❑ PERINATAL / NEONATAL

❑ Yes ❑ No — In your professional medical opinion, is ground transport absolutely contraindicated?
If so, why:

Provider Certification: by signing this form, you are certifying:

1. **In your professional medical opinion, the services described are medically necessary and are covered services under the Maryland Medical Assistance Program.**
2. **You understand that misrepresentation or falsification of essential information which leads to inappropriate payment may be subject to investigation and sanction and/or penalty under applicable Federal and/or State law.**

Signature of Physician	Date Signed	PRINTED NAME of Physician	
9-Digit Medical Assistance Provider Number or NPIN		PRINTED Address	
		Telephone Number	