Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
General Transportation Transmittal No. 35
April 29, 2024

To: Air Ambulance Providers

From: Jamie Smith, Director
Office of Long Term Services and Supports

Subject: Revised Maryland Medicaid Provider Certification Form for Rotary Wing Air Ambulance Transportation beginning May 1, 2024

Note: Please ensure the appropriate staff members in your organization are informed of the contents of this transmittal.

The purpose of this transmittal is to introduce the revised Maryland Medicaid Non-Emergency Medical Transportation (NEMT) Provider Certification for Air Ambulance Transport Form. This transmittal should be used in conjunction with Provider Transmittal (PT) 18-23, which details the criteria for air ambulance services, rate of reimbursement, provider eligibility and enrollment, claims submission, and required documentation, and PT 17-23, which outlines the payment procedures for Rotary (RW) air transport services effective October 1, 2022.

Responsibility of Sending Medical Facility:

Prior to air ambulance services being provided, the attending physician must complete this form in its entirety. This is a fillable form and may be completed and signed electronically as part of a HIPAA compliant electronic patient record. Alternatively, this form may be printed and completed by hand with a wet signature. This form must be stored as part of the medical record at the sending facility.

The completed form must be provided to the air ambulance transportation provider along with the following information:

1. Patient demographic sheet (to include the Maryland Medicaid identification number)
2. Patient History and Physical or Discharge Summary providing the following details:
    a. History of presenting illness/injury;

b. Date of presentation to the hospital;
c. Assessment and diagnosis;
d. Date and time of decision to transfer;
e. Date and time of contact with air ambulance provider;
f. Service(s) required not available at sending facility;
g. Attempts to transfer care to the closest appropriate provider;
h. Reason the receiving hospital was chosen;
i. Name of receiving provider at receiving facility; and
j. Indicate evaluation for use of a ground ambulance and why ground ambulance is not appropriate.

3. Detailed description of medical interventions (i.e.; medications, doses, medical equipment) required during transport.

Responsibility of Air Ambulance Transportation Provider:

To be eligible for reimbursement for air ambulance services, the transportation provider (and in the case of providers with multiple bases, the base of the responding unit) must be a Maryland Medicaid Provider. Successful claim processing will be based on the air ambulance provider providing the following information:

1. Service for which the participant is being transferred is medically necessary and not available at the sending facility;
2. The receiving facility is the closest appropriate provider;
3. The receiving facility is enrolled as a Maryland Medicaid Provider;
4. Transport is not primarily for the preference or convenience of the participant or provider;
5. Obtain a completed and signed Maryland Provider Certification for Air Ambulance Transport; and
6. Submit completed claim and documentation as detailed in PT 17-23.

If you have questions regarding the contents of this transmittal, please contact Michael Robinson, Chief, Division of Community Support Services, at (410) 767-1726 or michael.robinson1@maryland.gov.

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Medicaid Non Emergency Medical Transportation (NEMT)
Provider Certification Form for Air Ambulance Transport

Must be completed by the treating physician at the sending hospital, as a physician order for care.

Provider Certification Forms are required to validate that a Medicaid participant is being transported in the least expensive, clinically appropriate mode of transportation. Incomplete and illegible forms will be returned to the provider for completion, which may delay transportation services.

As outlined in Provider Transmittals 17-23 and 18-23, approval for air transportation is contingent upon: 1) Medical Necessity, 2) The clinical contraindication of ground transport, 3) Receiving facility must be a Maryland Medicaid provider, and 4) the Air transport provider must be a Maryland Medicaid provider.

All fields are required to be completed. Completed forms shall be provided to the Air Transportation Provider prior to transport. Transportation Providers shall submit this form as part of the complete claim submitted to the Utilization Control Agent for Maryland Medicaid.

EMTALA rules apply for air ambulance requests. *

Patient Information

Full Name	
Date of Birth MMDDYYYY	Medical Assistance # 1234567891011

Patient Clinical Information

History of presenting illness/injury:
Pertinent Signs and Symptoms:
Cause of injury or illness: ☐ Work-related incident ☐ Motor vehicle accident ☐ Violence or a criminal act ☐ None of the listed
Reason for air request: ground transport > 60 minutes, unavailable, terrain inaccessible. Must attach proof.
In your professional opinion, why is ground transport contraindicated? Time of decision to the closest appropriate facility
Interventions required during transport List all machines, medications, devices, etc.
Has the patient been stabilized prior to transfer? ☐ Yes ☐ No, provide a detailed explanation.*

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Sending Facility Information

Facility Name		NPI#	Medicaid Provider #
Address	City	State	Zip
Patient Location Building, Unit, Floor, Room		Patient Facility Entry Date	
Transport Request Date MDDYYYY		Transport Request Time ☐ a.m. ☐ p.m.	
Contact Name		Contact Title	
Please check the box below for your preferred method of contact.			
☐ Contact Phone	☐ Contact Fax	☐ Contact E-mail	
Attending Physician (please print):			
Specialty needed at receiving facility, not available at sending facility. Select all applicable. ☐ Cardiac Intervention ☐ CICU ☐ Endovascular Treatment of Ischemic Stroke ☐ ICU ☐ Neuro ☐ NICU, level ☐ PEDS ☐ PEDS Specialty ☐ Perinatal Center ☐ PICU ☐ Stroke ☐ Surgery ☐ Trauma Center, level____ ☐ Burn Unit			

Receiving Facility

Facility Name			
Address	City	State	Zip
Building, Unit, Floor, Room		Report Made To please insert name and phone #	
Contact Name		Contact Title	
Contact Phone	Contact Fax	Contact E-mail	
Accepting Physician		Medicaid Provider or NPI Number	
Accepting Service			
If the transfer is originating within Maryland, is this facility the closest appropriate facility per MIEMSS Inter-Hospital Transfer Resource Manual ☐ Yes ☐ No, explain below the reason for selecting the facility. Please provide your explanation:			

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Attestation

By completing and signing this form, you attest that in your professional medical opinion, the services described are covered services under the Maryland Medicaid Program and are medically necessary as defined under COMAR 10.09.36.01B(13). By your signature, you further acknowledge that submitting or causing the submission of false or fraudulent Medicaid claims for payment to the State is an illegal act, which is subject to civil and criminal penalties, including imprisonment.

Physician's Signature Electronic signature meeting CMS criteria are permissible.	Date
Print Name	
Medicaid Provider or NPI Number	Telephone

** Effective October 1, 2022, Telligen assumed the responsibility for reviewing and authorizing Air Ambulance Rotary Wing (RW) claims. Air Ambulance Provider Claims must be submitted through Qualitrac at https://telligenmd.qualitrac.com/. Air Ambulance Transport providers may access to the Qualitrac portal, as well as Provider Portal Registration.