



Medical Assistance (MA) Transportation Program
Out of Service Area Certification Form



MA out of service area transportation may be requested to allow eligible riders to access medical services outside of their service area of residence if:

- (1) appropriately qualified MA enrolled providers are unavailable within their service area of residence and/or
- (2) a unique medical condition prohibits treatment within their service area of residence.

** This request must be completed legibly, in its entirety & allow a minimum of 48 hours for processing. **

Rider Name _____ Date of Birth ____ / ____ / ____

County of residence of rider (please check one) ____ Carbon ____ Lehigh ____ Northampton

TO BE COMPLETED BY A PHYSICIAN (Please print)

Physician Name _____ MA Provider # _____

Medical Location Name & Address _____

Please indicate which applies to you:

____ I am the physician referring this rider to a medical service outside of their service area

____ I am the physician who will be providing the medical service which is located outside of the service area

1. What type of medical service is being sought outside of service area: ____ a primary care provider ____ a specialist
____ other, please explain _____

Name and complete address of medical service location outside of service area _____

2. Length of time request is needed (6 months maximum) 3 Months 6 Months Other: _____

3. Is the requested provider a qualified MA provider? ____ yes ____ no

4. Is the service to be provided a MA covered service? ____ yes ____ no

5. Is the service available within the rider's service area of residence? ____ yes ____ no

If yes, explain why the service is not being provided in the service area of residence: _____

Affirmation of Information:

I hereby certify that, to the best of my knowledge, the information contained herein is true, correct, and complete.

Signature _____ Date _____