PCS

Medical Necessity for Air Medical Transport

Date of Service: ____________________________ Patient Name: ____________________________ Diagnosis: ____________________________

Presenting time-critical condition / required intervention:
_____________________________________________________________________________________________________________________________________________________________________________________________

Ground transport would have been hazardous due to the LENGTH OF TRANSPORT.
Ground transport time of ___________ minutes versus air transport time of ___________ minutes.

The following information is required for INTERFACILITY TRANSPORTS:
The attending physician for (enter patient name) ____________________________________________,
at (enter referring hospital name) ____________________________________________, has directed
emergency transportation to the services of (enter receiving physician name) ____________________________,
at (enter receiving facility and unit name) ____________________________________________.

Sending physician has certified under EMTALA that air transport is needed: ☐ YES ☐ Not Verified

Based on an assessment of this patient, emergent transportation is required for the following reasons (mark all that apply, minimum of one from both sections):

SECTION 1 - REASON(S) FOR METHOD OF TRANSPORT:

☐ The patient’s condition was TIME CRITICAL, requiring rapid air transportation in order to minimize morbidity / mortality.

☐ The patient’s condition met established criteria for transport based on published standards for appropriate utilization of air transport from the EMS, cardiac, trauma, pediatric, or neonatal communities.

☐ During transport, the patient’s condition required critical care life support and monitoring by an ALS crew with an attending RN present (specify care): ☐ Intubated ☐ TPA infusion ☐ IABP ☐ ETCO₂ Monitoring ☐ EKG ☐ IV Medications, titrated drips (specify Medications) ☐ Other

☐ Ground transport would have been hazardous and / or delayed due to: ☐ Rush hour / traffic conditions ☐ Bridge out/road construction ☐ Adverse weather conditions

SECTION 2 - REASON(S) PATIENT REQUIRED TRANSPORT:

☐ The receiving facility provides specialized care, treatment, and diagnostics not available at referring facility or a facility that may have been closer to the scene (define care required and facilities needed)

☐ No beds or needed specialist available at referring facility (describe unit/bed type/specialist not available at referring facility)

☐ Specialized maternal / neonatal care required with high-risk obstetrician and / or neonatal ICU not available at referring facility. Other maternal / neonatal specialized services needed (describe care required and facilities needed)

☐ Specialized Trauma Care required with diagnostic and trauma surgical facilities readily available. (Describe services not available at referring facility or services needed for scene transport),

Mechanism of injury: ☐ MVC rollover ☐ MVC with ejection ☐ Head on collision ☐ Same vehicle occupant fatality ☐ Extrication time > 30 minutes ☐ Crash speed change > 20 mph ☐ Pedestrian struck by motor vehicle ☐ Trauma Patient ☐ Pregnant trauma patient ☐ Blast injury ☐ Two or more proximal extremity fractures ☐ Fall 20 > feet ☐ Other (describe):

☐ Specialized cardiac care facility required with Cath Lab facility and surgical backup readily available ☐ High-risk cardiac surgical candidate ☐ Cath Lab at referring facility not open all hours ☐ Cath Lab at referring facility has no surgical back up (Describe specialized cardiac services needed)

CONTENTS OF FORM COMPLETED BY (INITIALS): ____________ LICENSE/CREDENTIAL ____________

The undersigned attests that he/she has reviewed the foregoing and it is accurate (Signer Special Instructions: OK—Physician or RN only)

Printed Name of signer. Signature of Ground crew; Referring/Receiving MD (signature or “per voice order”)/RN/PA/NP/Discharge Planner/Program Medical Director Date Signed ____________ / ____________ / ____________

☐ CHECK IF SIGNER IS TRANSFER PROGRAM MEDICAL DIRECTOR

Form: PCS-01 VER Apr 2011 – all states (ex CA)
AUTHORIZATION AND CONSENT

SECTION I

PATIENT NAME: ________________________________ FLIGHT #: ________________________________
UNIT/BASE I.D.: AirLink Date Of Service: ________________________________ TIME: ________________________________ (Military Format)

CONSENT TO TREATMENT. The undersigned consents to air medical transportation and the performance of medical services, administration of medications and blood or blood products, and other medical procedures (“Services”) by the company listed above (“Provider”), as deemed appropriate by Provider’s medical crew or medical control personnel. I understand that medical care is not an exact science and no guarantees have been made regarding the outcome of treatment.

RELEASE OF INFORMATION. I authorize Provider and any other holder of information about me to disclose all or any part of my medical record or other information needed to determine my eligibility for benefits or the amount of benefits payable for Services rendered by Provider, now or in the future, to any financially responsible party, including but not limited to: the Centers for Medicare and Medicaid (CMS), Medicaid, their intermediaries or carriers, Worker’s Compensation carriers, health or liability insurers, or any other insurance organization or billing agent (collectively, “Insurer”). I authorize any holder of medical and billing information about me to release to Provider or any Insurer any information necessary for billing and payment purposes. I consent to the use of a copy of this authorization in lieu of the original.

ASSIGNMENT OF BENEFITS & LIEN. I request and authorize direct payment to Provider of any Medicare and other insurance benefits payable to me or on my behalf for Services rendered by Provider, now or in the future. At Provider’s election, I also assign to Provider all of my rights and interest in all such insurance benefits or proceeds, including but not limited to the right to appeal any denial of benefits or to file any lawfully authorized lien necessary to secure payment from any third party or a third party’s Insurer. I further intend for this Assignment & Lien to create a secured interest under the applicable Uniform Commercial Code. Accordingly, I hereby grant to the Provider a primary, non-contingent secured interest in all Proceeds to the extent permitted by law for the purpose of securing payment of my charges, which secured interest shall attach and also be automatically perfected effective as of the date and time that my condition first arose. I further authorize Provider to file the form(s) normally filed with the secretary of state or other governmental agency relating to such secured interests, and to make such filings in all relevant jurisdictions as Provider sees fit in its sole discretion. I agree that once payment in-full has been made towards all outstanding Charges to the full extent permitted by law or contract, such secured interest shall be removed or terminated solely upon my written request sent through the U.S. Postal Service Certified Mail. Consistent with these terms, I hereby direct any and all Payers, to pay the Proceeds directly to, immediately to, and exclusively in the name of, Provider to the extent of my Charges. I understand and agree to immediately remit all payments received from insurance for those services. I agree to cooperate with Provider or its agent in collecting any such benefits. This assignment shall not obligate Provider to file any appeal or perfect any such lien and nothing herein shall relieve me from direct financial responsibility for any charges not paid by an Insurer.

FINANCIAL RESPONSIBILITY. I acknowledge that many Insurers will only pay for services that they determine to be medically necessary and that meet other coverage requirements. For example, some Insurers require prior authorization for certain services. If my Insurer determines that the Services, or any part of them, are not medically necessary or fail to meet other coverage requirements, the Insurer may deny payment for that Service. Notwithstanding any other provision herein, I agree that if my Insurer denies all or any part of Provider’s charges for any reason, or if I have no insurance, I will be personally and fully responsible for payment of Provider’s charges. Should my account be referred to an attorney or collection agency, I agree to pay actual attorney’s fees and collection expenses.

The undersigned certifies that he/she has read the foregoing, and is the patient, the patient’s legal representative or is duly authorized by the patient as the patient’s agent to execute this Authorization and Consent form and to accept its terms, except as noted below.

SECTION II

Mark the Appropriate Box and Sign Below:

Signer below is the: [ ] Patient [ ] Authorized Representative (See Back for Definition) [ ] Crew Member (NO Representative was available/willing to sign)

If signature is “Authorized Representative” or “Crew Member” NO FINANCIAL OBLIGATIONS are placed upon the signer. (Exceptions are spouse, parent of minor child; guardian; or Power of Attorney).

Signature: ____________________________________________________________________________ Date______________________/______/______

Signature of Crew if patient signs using an “X” ▶▶ Witness Signature (if patient signs with an “X”) ____________________________________________________________________________

SECTION III

If Authorized Representative, identify relationship to the Patient (see back for definition):

[ ] A (Legal Guardian) [ ] B (Recipient of Government Benefits for patient) [ ] C (Spouse, Parent, or other relative with responsibility for patient’s affairs) [ ] D (Agency Rep that provided service to patient)

[ ] Patient unable to sign (check box, if appropriate and explain below):

SPECIFIC MEDICAL, MENTAL, or LEGAL (e.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN

SECTION IV

RECEIVING FACILITY ACKNOWLEDGMENT

FACILITY NAME: ________________________________ CITY: ________________________________ ST: ________________________________

REPRESENTATIVE SIGNATURE: ________________________________ TITLE/credential: ________________________________

PRINTED NAME OF SIGNER: ________________________________ (DATE)______________________/______/______ (TIME)____________________/

The patient named on this form was received by this facility at the date and time indicated above. This signature does not constitute acceptance of financial or any other manner of responsibility for this patient or for the services rendered to this patient, nor does it constitute acceptance of or agreement as to any matter set forth in this form other than that contained in the preceding sentence.

ACF Ver JUL10