

# Physician Certification Statement

## Medical Necessity for Air Medical Transport

Flight # \_\_\_\_\_

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Presenting time-critical condition / required intervention: \_\_\_\_\_

**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, and 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 due to the **LENGTH OF TRANSPORT**. Ground transport time of \_\_\_\_\_ minutes versus air transport time of \_\_\_\_\_ minutes.
- Ground transport would have been hazardous and / or delayed due to:  Rush hour / traffic conditions  Bridge out / road construction  Adverse weather conditions require fixed wing transport

### 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 needed for direct scene transport) \_\_\_\_\_
- Mechanism of injury:**  Fall > 20 feet  MVC with rollover  Pedestrian struck by motor vehicle  MVC with ejection  
 Same vehicle occupant fatality  Blast injury  Extrication time > 30 minutes  Trauma patient > 55 years of age  
 Head on collision  Two or more proximal extremity fractures  Pregnant trauma patient  Crash speed change > 20 mph
- 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:

\_\_\_\_\_ X \_\_\_\_\_

**Printed Name** of Referring/Receiving MD/RN/PA/Discharge Planner/**Program**  
Medical Director

**Signature** of Referring/Receiving MD (signature or "per voice order")/RN/PA/Discharge Planner/**Program** Medical Director

**CHECK IF SIGNER IS AIR TRANSPORT PROGRAM MEDICAL DIRECTOR**

## CHANGE NOTES

- 1) Interfacility Block: This block has been re-written so to prevent any implication that the referring physician actually completed this form in cases where he/she did not.
- 2) Section 2; first paragraph: Wording was added: "...or a facility that may have been closer to the scene..." This was added include circumstances where the patient was not flown to the closest available facility because the receiving facility was determined to be more appropriate to evaluate and/or treat the patient's condition .

- 3) Bottom section above signature lines, line added:

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

This line was added to clarify who actually completed the form, as opposed to who signed it. Often different individuals perform each function, and clarification is required to eliminate confusion for audit purposes.

- 4) Bottom section below signature lines: Added "Program Medical Director" to indicate that it is appropriate for the Medical Director of the transporting program to sign the certification form.
- 5) Last block of form:

CHECK IF SIGNER IS AIR TRANSPORT PROGRAM MEDICAL DIRECTOR

Added for the transporting program Medical Director to check if he/she signed to clarify their relationship with the transport program.

# Air Methods Corporation

## CONDITIONS OF SERVICE AND CONSENT TO TREAT

### REQUIRED TO BE COMPLETED FOR EMERGENCY TRANSPORTS

#### **SECTION I**

PATIENT NAME: \_\_\_\_\_ FLIGHT #: \_\_\_\_\_

UNIT/BASE I.D.: \_\_\_\_\_ 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.** 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 understand that I am financially responsible for the services rendered by Provider 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. All delinquent accounts shall bear interest at twelve percent per annum, not to exceed the maximum amount permitted by law.

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 Conditions of Service and Consent to Treat and to accept its terms, except as noted below.

#### **SECTION II**

##### **Mark the Appropriate Box and Sign Below:**

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

If signature is "Designated Representative" or "Crew Member" **NO FINANCIAL OBLIGATIONS** are placed upon the signer, and no **CONSENTS** are applicable. (Exceptions are 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 Designated 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: \_\_\_\_\_

(DATE) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (TIME) \_\_\_\_\_ AM/PM or MILITARY FORMAT

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.

## CREW INSTRUCTIONS

All sections of this form must be filled out in their entirety, as directed below to ensure regulatory compliance and proper reimbursement for transport:

### **FOR EMERGENCY TRANSPORTS ONLY**

#### **SECTION I**

Complete all fields for every transport:

- Patient Name (First & Last)
- Flight Number
- Unit/Base ID (Base name, code, or location)
- Date of Service is date services INITIATED—enter date the patient was reached to begin assessment and care
- TIME (Time the patient was reached—express in military time (i.e. 16:10 for 4:10 p.m.)

#### **SECTION II**

Check Boxes:

- **Patient:** Check this box if the patient is the signer.  
ALWAYS attempt to obtain a patient's signature. If the patient is able to sign this form, then the patient MUST sign. (If a patient refuses to sign the form, there is no alternative. No insurance can be billed.)
- **Designated Representative:** Check this box if the patient cannot sign, and there is a designated representative present and willing to sign (Designated signer incurs no financial responsibility nor gives consent by signing unless they are the parent, guardian or power of attorney).
- **Crew Member:** Check this box if the patient cannot sign, and there is no designated signer (by definition below) who is present and willing to sign to acknowledge the transport.

**Signature:** Signature of the signer identified by check box described above.

**Date:** Date of the signature (Signer MUST sign within the time-frame of the transport)

**Witness Signature:** This line is used ONLY when the patient signs with an "X". A crew member may sign as witness.

#### **SECTION III**

Check Boxes: If a "Designated Representative" signs, check the box to indicate the signer's relationship to the patient. Any person not meeting one of the definitions below may not sign. If there is no designated representative present and willing to sign, leave these boxes blank, in which case the crew must sign.

- A. Beneficiary's legal guardian.
- B. A relative or other person who receives social security or other governmental benefits on the beneficiary's behalf.
- C. A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs (i.e. spouse).
- D. A representative of an agency or institution that did not furnish the ambulance services, but which furnished other care or services to the beneficiary.

Check Box – Patient Unable to Sign: To be checked any time patient is UNABLE to sign for a medical, mental, or legal reason.

SPECIFIC MEDICAL, MENTAL, or LEGAL REASON PATIENT UNABLE TO SIGN: Line is provided for crew to briefly describe the medical or mental reason patient CANNOT sign on their own behalf. Also, two primary legal reasons a patient cannot sign includes minor children or if the patient is a prisoner. In both cases those who stand in the place of the patient would sign as a Designated Representative (parent; officer having custody of prisoner).

#### **SECTION IV**

Completion of this section is required ONLY when the patient is UNABLE to sign, AND Designated Representative is not available OR willing to sign (in which case the crew signed). Completion must be by a person with clinical knowledge of the patient and who can represent (who works for) the receiving facility. When this section is required, all fields must be completed as indicated: **Facility Name** (receiving facility); **City, State** (physical location); **Representative Signature; Credential and/or Title of the signer; and Date and Time** patient was received at the receiving facility.

**QUESTIONS REGARDING COMPLETION OF THIS FORM MAY BE REFERRED TO THE DIS UNIT**

**ANYTIME, 24/7...CALL: 888-540-7004**

## **CHANGE NOTES**

- 1) Section I: “Multi-Patient” field was removed. There are other sources for that information and it is no longer required on this form.
- 2) Section I: Time Field designated as Military Time, thus AM/PM is no longer required.
- 3) Section III: Narrative “Reason Patient Unable to Sign” line includes “Legal reason” such as because patient is minor child or a prisoner.
- 4) Section IV: Disclaimer statement at bottom of form to acknowledge that person signing Facility Acknowledgement is not accepting of any financial or any other kind of responsibility for the patient whose named in the form, on behalf of the facility.
- 5) GENERAL: No longer is a facility acknowledgement required if either the patient signs OR a designated representative signs. If the patient does not sign nor is there representative present OR willing to sign and the crew signs, that is the ONLY situation in which there must be a facility acknowledgement signed.
- 6) GENERAL: Date of Service and Time indicated in Section I at top of form is now defined as the time crew reaches the patient, NOT the time that the transport was completed.
- 7) GENERAL: Date included in Section IV – Facility Acknowledgement may be a different day than the Date of Service at the top of the form in cases where the patient was initially reached before midnight of one day, and is delivered to the receiving facility after midnight of the next day. Date and Time in the Facility Acknowledgement should be the approximate date/time that the facility accepted responsibility for the patient and began assessment/treatment.

# Patient Transfer Packet



Dispatch: 314-655-4050  
1-800-325-9191  
FAX: 314-655-4058  
1-877-286-9292

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## CHECKLIST FOR INITIAL DISPATCH

...please have available when you call:

- ✓ Patient Name: \_\_\_\_\_
  - ✓ Caller's Name/Title \_\_\_\_\_ Phone #:( ) \_\_\_\_\_
  - ✓ Referring Hospital & Unit: \_\_\_\_\_
  - ✓ Referring M.D. (full name) \_\_\_\_\_
  - ✓ Receiving Hospital & Unit: \_\_\_\_\_
  - ✓ Receiving M.D. (full name) \_\_\_\_\_
- 

## CHECKLIST FOR TRANSFER

...please enclose the following copies:

- \_\_\_ Insurance Cards, Copies of Front and Back – for MVA, both Health and Auto
- \_\_\_ Transfer or COBRA Sheet
- \_\_\_ Hospital Face Sheet

...please obtain the following signatures:

- \_\_\_ Physician – Medical Necessity Form
- \_\_\_ Patient or Family – Patient Agreement Signature Sheet

Please fax missing information as soon as possible to the above number.