



FLIGHT FOR LIFE/THEDASTAR PATIENT TRANSFER:

FFL 800-344-1000 / ThedaStar 800-236-2066

Patient Name: _____

Date of Transport: _____

IMPORTANT INSTRUCTIONS!

It is preferable that the following form (enclosed) be completed by the referring facility prior to patient transport. Medicare, Medicaid and most insurers require us to submit this form before reimbursement of transportation costs will be considered.

Forms

Must be signed by:

Authorization and Assignment of Benefits..... Patient or family member

THE COMMUNICATION CENTER WILL REQUEST THE FOLLOWING INFORMATION:

- | | |
|--|--|
| ☐ Requesting Agency and Unit | ☐ Patient Weight |
| ☐ Your Name | ☐ Age |
| ☐ Phone Number (area code and extension) | ☐ Male or Female |
| ☐ Reason for Transfer | ☐ LOC |
| ☐ Receiving Hospital and Unit (for in-patient transfers <i>Comm Center</i> will confirm bed availability with receiving hospital) | ☐ Airway |
| ☐ Name of Contact Person at Receiving Hospital | ☐ Recent Vital Signs |
| ☐ Receiving MD | ☐ IVs/Drips (prefer two IVs; one may be capped) |

CHECKLIST FOR TRANSFER:

Include copies of the following:

- | | |
|--|---|
| ☐ Patient Information/Face Sheet | ☐ Pre-hospital EMS Report, if applicable |
| ☐ Physician's Notes | ☐ Discharge Summary, if applicable |
| ☐ Nurse's Notes | ☐ Insurance Card (front & back scanned) |
| ☐ X-Rays/CT Scans/Ultrasound/EKGs | ☐ <i>Authorization and Assignment of Benefits</i> form |
| ☐ Lab Results | |



FLIGHT FOR LIFE

Authorization and Assignment of Benefits

Patient Name: _____ Transport Date: _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to FLIGHT FOR LIFE (FFL)/ThedaStar for any services provided to me by FFL/ThedaStar now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by FFL/ThedaStar, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to FFL/ThedaStar any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to FFL/ThedaStar. I authorize FFL/ThedaStar to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to FFL/ThedaStar and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by FFL, now, in the past, or in the future. A copy of this form is as valid as an original.

SIGNATURE SECTION:

ONE of the following three sections **MUST** be completed.

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

x _____
Patient Signature or Mark Date

If the patient signs with an "X" or other mark, someone should sign below as a witness. This can be an ambulance crew member.

x _____
Witness Signature Date

Witness Printed Name

NOTE: If the patient is a minor, the parent or legal guardian should sign in this section

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.
Reason the patient is physically or mentally incapable of signing: _____

Authorized representatives include only the following individuals (check one):

- ☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

Representative Signature Date Printed Name of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, **and**
(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (**must** be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason patient incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

x _____
Signature of Crewmember Date Printed Name of Crew Member

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

x _____
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B above cannot be obtained)

If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by § 164.506 © of HIPAA.

- ☐ Patient Care Report (Signed by representative of facility) ☒ Facility Face Sheet/Admissions Record
☐ Patient Medical Record ☐ Hospital Log or Other Similar Facility Record

Please fax to Billing at 414-677-5018



Physician Certification Statement For Critical Care Transport

Date: _____ Patient Name: _____ Transport #: _____

From: _____ To: _____

Complete for all patient transports:

General Criteria for Transport (check all that apply):

- ☐ Equipment and/or personnel to care for injury/illness not available.
- ☐ Patient required specialized interventions/tests not available at referring facility.
- ☐ Required therapeutic regimen must be initiated within limited time frame.
- ☐ Time of transfer between critical care units must be minimized.
- ☐ Safe and legal transfer requires nurse and/or critical care paramedic, at a minimum.
- ☐ Critical care environment required during transfer.
 - ☐ Airway control/positioning or suctioning
 - ☐ Continuous IV therapy
 - ☐ Ventilator dependent / advanced airway intervention or monitoring
 - ☐ Cardiac monitoring
 - ☐ Is medicated and requires monitoring
 - ☐ Danger to self or others
 - ☐ Acute condition: Please explain _____

- ☐ Land transport would be hazardous and delayed due to road and/or traffic conditions.
- ☐ Disaster/Triage decision.
- ☐ Patient requires medical supervision during transport. .
- ☐ Immobilized (due to recent fracture or possible fracture; contracted and cannot sit up in wheelchair; suffers from paralysis)
- ☐ Requires treatment not available at sending facility. Please indicate below:
 - ☐ Medical (e.g. AMI, Cardiac Assist Device, CNS, etc.)
 - ☐ Surgical (neurosurgical, surgery urgently required, replantation, transplantation)
 - ☐ Trauma care
 - ☐ Perinatal care
 - ☐ Neonatal care

Comments: _____

In my opinion, critical care transport is required for this patient for the reasons indicated above. I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. It is my opinion that transportation by any other means may place the patient's general welfare in jeopardy or cause impairment of bodily function. I further understand that this information will be used by the Department of Health and Human Services, Healthcare Financing Administration, and/or its agents, to support the determination of medical necessity for ambulance service.

Signature

TITLE

DATE

PRINTED NAME

Air transportation provided by Intermountain Health