Thank You For Using *MEDEVAC ALASKA*

ATTACHED YOU WILL FIND ALL THE PAPERWORK YOU NEED TO ARRANGE MEDICAL TRANSPORT WITH MEDEVAC ALASKA. WE THANK YOU FOR TRUSTING US WITH THE CARE OF YOUR PATIENT.

24/7 Communications Center

1-877-985-5022

1-907-310-9001

1-251-348-7644

www.medevacalaska.com

Please have the following completed and ready for the Medical crew prior to arrival:

- ☐ 2 Copies of the patient chart including the face sheet.
- ☐ The ***MEDEVAC ALASKA*** "Certificate of Medical Necessity" signed by the appropriate medical provider.
- ☐ Copies of Xrays, MRI, CT films/disks.

COMBINED NOTICE TO MEDEVAC ALASKA PATIENTS

HIPAA Notice of Privacy Practices

Emergency personnel with the Medevac Alaska are providing you with a separate pamphlet, entitled "Notice of Privacy Practices," as required by the Code of Federal Regulations (45 CFR Section 164.520). This notice describes how medical information about you may be used and disclosed and how you can get access to such information. Please review it carefully.

Medevac Alaska is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to protect the privacy of healthcare information obtained when treating you (known as protected health information or PHI) and to provide you with a notice of privacy practices concerning the use of such information shortly following the time of service. This notice describes how and when our agency can use and disclose your PHI along with describing your legal rights pertaining to the use and disclosure of such information. This notice also provides contact information for questions and for obtaining further assistance if you need more help. Our agency is required to abide by the terms of this notice as long as it is in effect. We reserve the right to change the terms of this notice and apply such changes to all protected health information that we maintain. A copy of our current (or revised) privacy policy is always available at our business office and on our website at www.medevacalaska.com.

By signing this form I, or the person signing for me, acknowledge receiving a "Notice of Privacy Practices" from emergency personnel with Medevac Alaska. I understand that the Notice I received explains my rights and contains information to assist me if I should have questions or a complaint.

Permission to Use Healthcare Information for Billing Purposes and Financial Responsibility Statement

By signing this form, I authorize Medevac Alaska to release any information, including protected health information or PHI, to any insurance company, insurance company representative or other authorized third party for the purpose of paying my ambulance fees and charges. I authorize any holder of healthcare information or documentation, including PHI, needed to determine benefits or benefits payable for related services or any service rendered to me now or in the future to be released to Medevac Alaska if requested. I authorize that direct payment be made by any insurance company or other third party for any ambulance fees and charges that are reimbursable and owed by me to Medevac Alaska.

If I am insured by a federal health insurance plan, such as Medicare or other forms of federal health insurance, by signing this form I authorize Medevac Alaska to release any information, including PHI, to the Department of Health and Human Services, the Center for Medicare and Medicaid Services or their contracted agents, for the purpose of paying my ambulance fees and charges. I understand that such insurance plans require a co-payment or even a deductible that I or my supplemental insurance may be responsible for paying.

If I am an active duty member of the United States Military, I authorize Medevac Alaska to release any information, including PHI, to the Department of Defense or my command upon written request by appropriate authority.

Finally, by signing this form I understand that if I am insured, I am responsible for providing my insurance information to Medevac Alaska for the purpose of paying all ambulance fees and charges. I also understand that in the event I am uncooperative or refuse to provide my insurance information and/or subsequent information to support the filing of an insurance claim on my behalf, Medevac Alaska may determine that I alone must pay all ambulance fees and charges directly and that I will be responsible for paying these fees and charges within thirty (30) days of such a determination.

All patients please read this statement and sign: By signing this statement I acknowledge that I have read, understand and agree to the terms and conditions explained above. Furthermore, I acknowledge receiving a separate pamphlet entitled "Notice of Privacy Practices" from emergency personnel with Medevac Alaska explaining HIPAA and my rights as described by the law.

_____

Patient or Responsible Party Name_____

Patient or Responsible Party Signature_____

Date_____Incident/Call/Report Number:_____

MEDEVAC ALASKA

Medevac Alaska 24/7 Dispatch
(877) 985-5022
907-538-1620
251-348-7644

CERTIFICATE OF MEDICAL NECESSITY

SECTION 1 – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ This CMN is Valid for ☐ Today or ☐ Date Range: _____ to: _____ (no more than 60 days)

Origin: _____ Destination: _____

Is the patient's stay covered under Medicare Part A (PPS/DRG?): ☐ YES ☐ NO

Closest Appropriate Facility? ☐ YES ☐ NO If NO, why is transport to a more distant facility required? _____

_____

If hospital to hospital transfer, what services at destination that are required: _____

If hospice pt, is this transport related to the pt's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION 2 – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. The following questions must be answered by the medical professional signing below for this form to be valid:

1) Describe the **MEDICAL CONDITION** (physical and/or mental) of this patient **AT THE TIME OF AMBULANCE TRANSPORT** that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:_____

_____

_____

2) Is the patient "bed confined" as described in the following? To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

☐ YES. ☐ NO

3) Can the patient be safely transported by car or wheelchair van? (i.e. seated during transport without a medical attendant)

☐ YES. ☐ NO

4) In addition to items 1-3 above, please check any of the following conditions that apply as supporting documentation. The supporting documentation must be maintained in the patient's medical records.

☐ Cardiac Monitoring Required ☐ Danger to Self/Others ☐ Patient is confused ☐ Contractures
☐ Requires Continuous IV Therapy ☐ Moderate/Severe Pain with Movement ☐ Patient is comatose
☐ Is Ventilator Dependent ☐ Need/Potential Need for Restraints ☐ Medical Attendant Required
☐ Special Isolation Precautions (i.e. Neutropenic, Contact, Airborne and/or Droplet) ☐ Non-Healed Fractures
☐ Requires Oxygen & unable to self-administer ☐ Orthopedic Device (Backboard, splint, pins, etc.) requiring special handling
☐ Hemodynamic Monitoring Required ☐ Unable to sit in chair/wheelchair due to decubitus ulcers
☐ DVT lower extremity that req. Special Positioning ☐ Morbid Obesity req. additional personnel to safely handle patient
☐ Other (specify): _____

SECTION 3 – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, *the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows*:

_____

_____ _____

Signature of Physician or Healthcare Professional | Date Signed

_____ _____

Printed Name of Physician or Healthcare Professional | Credentials (MD, DO, PA, NP, RN, CNS)

Form must be signed by patient's attending physician for repetitive transports (If 60 day option is checked above). For unscheduled transports, this form may be signed by a Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse or Discharge Planner if their attending physician is not immediately available.