Patient Transfer Packet

Please have the following paperwork completed and ready for the Medevac Alaska Flight or Ground Team prior to their arrival:

- Two (2) copy of the patient face sheet/ demographics
- Two (2) copy of the H&P, medication list, and discharge summary
- One (1) copy of the Medevac Alaska Certificate of Medical Necessity
- Copies of x-rays, CT, MRI, labs or other important results pertinent to patient transport

Medevac Alaska Dispatch:

1-877-985-5022

1-907-310-9001

Have additional questions?

Our crews are happy to assist at the bedside, or you can contact the Dispatch number and be put in touch with either the on-duty Operations Manager or the on-duty nurse

Alaskan Owned and Operated

hhtp://www.medevacalaska.com/

MEDEVAC ALASKA

Medevac 24/7 Dispatch TEL (877) 985-5022 (907)310-9001 Fax 907-361-2215

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 patient, is this transport related to the patient's terminal illness? ☐ YES ☐ NO

Describe:_____

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.

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): _____

5) If air transport is covered under a portion of this medical necessity, please specify why air transport is necessary vs. all other modes:

☐ Long Distance: pt.'s condition requires rapid transport over long distance ☐ Pick up point is not accessible by ground transportation

☐ Unstable Patient with need to minimize out of hospital time ☐ Traffic patterns preclude ground transportation at this time

☐ 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)

MEDEVAC ALASKA Ambulance Signature / Claim Submission Authorization Form

Patient Name: _____ Run Number: _____ Transport Date: _____

Privacy Practices Acknowledgment: By signing below, the signer acknowledges that Medevac Alaska LLC provided a copy of or access to the Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. ****A copy of this form is valid as an original****

Section I – Patient Signature

The patient must sign here unless the patient is physically or mentally incapable of signing.
Note: If the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **MEDEVAC ALASKA** now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **MEDEVAC ALASKA** 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 **MEDEVAC ALASKA** 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 **MEDEVAC ALASKA**. I authorize **MEDEVAC ALASKA** to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing, or other relevant information about me to release such information to **MEDEVAC ALASKA** 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 **MEDEVAC ALASKA**, now, in the past, or in the future. I also authorize **MEDEVAC ALASKA** to obtain medical, insurance, billing, and other relevant information about be from any party, database, or other source that maintains such information.

If the patient signs with an "X" or other mark, a witness should sign below.

X_____ _____
Patient Signature Date

X_____ _____
Witness Signature Date

_____
Witness Address

Section II – Authorized Representative Signature

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

Describe the circumstances that make it impractical for the patient to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **MEDEVAC ALASKA** now, in the past, or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below.
My signature is not an acceptance of financial responsibility for the services rendered.

Authorized representatives include only the following individuals:

- ☐ Patient's legal guardian
- ☐ A relative or other person who receives Social Security or other governmental benefits on behalf of the patient.
- ☐ A relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs.
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e. ambulance services) but furnished other care, services, or assistance to the patient.

X _____ _____ _____
Representative Signature Date Printed Name of Representative

Section III – Ambulance Crew Member Signature

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.

Describe the circumstances that make it impractical for the patient to sign: _____
Name and Location of Receiving Facility: _____ Time:_____

The signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **MEDEVAC ALASKA.**

Ambulance Crew Member Statement (must be completed by crew member at the time of transport)
My signature below indicates that, at the time of service, the patient 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.***

X _____ _____ _____
Signature of Crewmember Date Printed Name and Title of Crewmember

Receiving Signature

(RN, Paramedic, MD, Family, Care Giver)

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

X _____ _____ _____
Representative Signature Date Printed Name of Representative

Medevac Alaska
NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Medevac Alaska is dedicated to protecting your medical information. We are required by law (45 CFR 164.520) to maintain the privacy of protected health information (PHI) and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information (PHI). Medevac Alaska is required by law to abide by the terms of this Notice. Medevac Alaska reserves the right to change the terms of this Notice, and any such changes would be effective immediately. If Medevac Alaska revises the terms of this Notice, it will make paper copies of this Notice of Privacy Practices available upon request. You may also request a paper copy of this Notice from us at any time.

Patient's Individual Rights: In addition to your right to receive communications of your PHI from us in a confidential manner, you have the following rights:

- The right to inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- The right to request restrictions on certain uses and disclosures of your PHI, but in some instances, we are not required to agree to your requested restriction, except that we must comply with your request that we not disclose to your health insurer information regarding treatment for which you pay for in full.
- The right to request an amendment of your medical information. In certain instances, we may deny your request, but, if denied, we will provide you with a written explanation for the denial.
- The right to receive an accounting of the disclosures of your medical information for six years prior to your request.
- The right to receive notice in the event of a breach involving your medical information.
- The right to complain to Medevac Alaska and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. To complain to us, please call our Privacy Officer, at (907) 268-1266. If you choose to file a complaint, you will not be retaliated against in any way.

Uses and Disclosures of PHI: Medevac Alaska may use and disclose your PHI without your written authorization:

- ***For Treatment Purposes***, examples include: Using your PHI to facilitate your proper care and disclosing your PHI in writing or via radio or telephone to a hospital or dispatcher center when proper for your treatment.
- ***For Payment Purposes***, examples include: Billing and seeking reimbursement, managing accounts, determining and reviewing medical necessity, and collecting outstanding accounts.
- ***For Purposes of Health Care Operations***, examples include: quality assurance activities, licensing, training programs, obtaining legal and financial services, conducting business planning, processing grievances and complaints, and creating reports for data collection purposes.
- For the treatment activities, payment activities, or health care operations of another health care provider (such as a hospital).
- To remind you of any scheduled appointments for non-emergency transportation or to inform you about other services.
- For other purposes permitted by law and for activities related to Medevac Alaska's compliance with the law.
- Unless you object, to inform family members or other concerned individuals involved in your care about your general condition, where you are being taken, and other general information.
- To report certain situations as required by law to public health authorities and law enforcement agencies (such as reporting a birth, death, or communicable disease, child or adult abuse or neglect, domestic violence, a knifing or shooting, a treat of violence being made, etc.)
- For health oversight activities such as audits or government investigations, inspections, disciplinary proceedings, etc.
- In judicial and administrative proceedings as required by a court or administrative order, or in response to a subpoena or other legal process compliant with HIPAA.
- To law enforcement in limited situations, such as when properly subpoenaed or when the information is needed to locate a suspect or stop a crime.
- For military, national defense and security and other special government functions.
- To avert a serious threat to the health and safety of a person or the public at large.
- For workers' compensation purposes.
- To Coroners, medical examiners, and funeral directors and authorized by law.
- If you are an organ donor, release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation.
- For research projects, subject to strict oversight and only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law.
- We may further use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other uses or disclosures of PHI other than those listed above, including the sale or marketing of your information, will be made only with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclose medical information in reliance on that authorization.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact *Medevac Alaska, 6160 Carl Brady Drive, Anchorage, AK, 99502, or telephone (907) 268-1266.*