



Patient Name

HEALTHNET AEROMEDICAL SERVICES

CONSENT TO TREAT AND ASSIGNMENT OF BENEFITS

The undersigned consents to transport by HealthNet Aeromedical Services. The undersigned also consents to the performance of medical services, administration of medications and other emergency procedures consistent with local medical and hospital protocols or as may be deemed appropriate and necessary according to instruction issued by the receiving physician or the HealthNet Aeromedical Services Medical Director.

Additionally, the undersigned authorizes, whether he/she signs as patient or authorized agent for patient, direct payment to HealthNet of any insurance benefits otherwise payable to or on behalf of the undersigned for ambulance services provided, including all emergency services at a rate not to exceed HealthNet's regular charges for such services. Further, the undersigned consents and/or authorizes that the patient agrees to pay any amount not paid by insurance to include such items as non-covered services, deductibles, and co-payments.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, HealthNet may disclose portions of the patient's record to any person or entity which may be liable for all or any portion of HealthNet's charges, including but not limited to insurance company, health care service plans, worker's compensation, welfare funds, responsible parties, employers, the Centers for Medicare and Medicaid Services, its agents, intermediaries and carriers on a need-to-know basis. Upon inquiry, HealthNet may also make available to the public certain information about a patient to the extent permitted by law, unless requested by the patient or his/her representative not to do so.

The undersigned authorizes any holder of medical and billing information about him/her to release to HealthNet any information necessary for billing purposes.

The undersigned certifies that he has read the foregoing, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this consent and accept its terms.

Patient/Legal Representative & Phone Number
(if patient is a minor, name of parent/legal guardian)

Date

If other than patient, indicate relationship

Witness

Note: Signature by anyone other than patient or legal guardian in no way indicates a responsibility to pay for services.

____ Patient unable to sign. Reason:

Physician Certification Statement for Ambulance Transportation

Section I - Patient Information

Date(s) of Service:

Last Name: _____

First Name: _____

Patient Transported from: _____

Patient Transported to: _____

Section II - Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. Supporting documentation for any boxes checked must be maintained in the patient's medical records.

Check all that apply:

- Bed Confined * All three below must be met to qualify for bed confinement.
 - Unable to ambulate*
 - Unable to get out of bed without assistance*
 - Unable to safely sit up in wheelchair*
- Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning
- Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
- Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- I.V. medications/fluids required during transport
- Special handling en route - isolation
- Contractures
- Non-healing fractures
- Moderate to severe pain on movement
- DVT requires elevation of lower extremity
- Morbid Obesity requires additional personnel/equipment to handle
- Orthopedic device (backboard, halo, use of pins in traction, etc) requiring special handling in transit
- Severe Muscular weakness and de-conditioned state precludes any significant physical activity
- Restraints (Physical or Chemical) anticipated or used during transport
- Danger to self or others - monitoring
- Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- Danger to self or others - seclusion (flight risk)
- Confused, combative, lethargic, comatose

Section III - Authorization

I certify that the information above represents an accurate assessment of the patient's medical condition on the date of service.

(Physician, RN or Other Signature)

(Physician, RN or Other Name Printed)

Date

This authorization must be completed and signed. For unscheduled or non-repetitive transports the authorization may be signed by the attending physician, physician assistant, clinical nurse, nurse practitioner, registered nurse or discharge planner (employed by the facility where the beneficiary is being transported) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.

Care Provider Certification Statement

Medical Necessity for GROUND Medical Transport



Date: _____ Diagnosis: _____ Flight Vector/HealthNet Trip #: _____
Presenting time critical condition/required intervention: _____

The following information is required for INTERFACILITY TRANSPORTS:

As the Care Provider for (enter patient name) _____, at (enter referring facility name) _____,
I am directing emergency transportation to the services of _____
(enter receiving MD/DO name)
at (enter receiving facility) _____, (and unit) _____.

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):

1 – REASON(S) FOR METHOD OF TRANSPORT:

- The patient's condition was **CRITICAL/URGENT**.
- The patient's condition met established criteria for transport based on published standards for appropriate utilization of transport services 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 (specify care):
 intubated TPA infusion IABP
 ETCO2 Monitoring EKG IV Medications, titrated drips
Specify medications _____ Other _____

2 – REASON(S) PATIENT REQUIRED TRANSPORT:

- The receiving facility provides specialized care, treatment, and diagnostics **not available at referring facility** (define care required and facilities needed).
- No beds available at referring facility (Describe unit/bed type 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 Level Trauma Care required with diagnostic and trauma surgical facilities readily available. (Describe services not available at referring facility.)

Mechanism of Injury: Fall > 20 ft. MVC with rollover Pedestrian struck by motor vehicle
 MVC with ejection Same vehicle occupant fatality Blast injury Extrication time > 30 minutes
 Trauma patient > 55 yrs of age Head on collision Crash speed change > 20 mph
 Two or more proximal extremity fractures Pregnant trauma patient Other

Cardiac Related Criteria:

- 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 at all hours
- Cath Lab at referring facility has no back-up (describe specialized cardiac services needed).

PRINTED Name of Care Provider

SIGNATURE of Care Provider