PATIENT ID STICKER HERE

LIFEFLIGHT OF MAINE

MEDICAL NECESSITY FOR TRANSPORT
LifeFlight of Maine, LLC
Tax ID: 01-0518516

Section 1: General Information

Patient Name: _____ **Date of Birth**: _____ **Date of Transport**: _____
Originating Facility: _____ **Destination Facility**: _____

CMS rules and regulations require that the patient is transported to the closest hospital with capability and capacity to care for them

Is the patient being transported to the closest facility that has the **capability and capacity** to provide them with the needed care? ☐ **Yes** ☐ **No**
IF NO, why is the patient being transported to another facility?:

_____

_____

What interventions or services is the patient receiving at the destination facility that are not available at the sending facility?:

_____

Section 2: Medical Necessity

Critical Care Transport is deemed necessary when a patient must be transported to receive interventions or services not available at the sending facility, and the level of care required exceeds that which can be provided by a Maine licensed Paramedic.

Describe the medical condition at the time of transport that requires the patient to be transported by the critical care transport team, and **why other methods of transportation are contraindicated**. Please include as much detail as possible.

_____

_____

Section 3: Reasonableness

A trip is reasonable when it utilizes the most appropriate type of vehicle for the patient condition, regardless of the availability of other alternatives.

Regarding the patient, please check all that apply:*

☐ An intervention is required within a discrete time period.
☐ Transport is emergent and time-dependent.
☐ Patient is unstable or has a high likelihood of instability.
☐ Alternate means of transport would increase risk of harm to the patient.
☐ Therapies will likely need to be adjusted / titrated during transport.
☐ Extended out of hospital time may pose a danger to the patient.

**Please note, the presence of a checked condition above will not alone establish necessity and reasonableness, but rather support the mode of transport.*

Section 4: Certification

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

Emergency transportation is based on certification of medical necessity from the appropriate ordering provider for which prior authorization is not required under federal law (25 C.F.R. Section 2590.715-2719-A), Medicare Advantage rules (42 CFR 410.40; Medicare Managed Care Manual, Chapter 4, Section 20.3, or Maine law (24-A M.R.S. Section 4320-C). I further certify that this transport was emergent.

☐**If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form 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:

X_____ _____
Signature of Physician* or Authorized Healthcare Professional Date Signed

_____
Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)

PATIENT ID STICKER HERE

OR

Patient Name: _____
Patient DOB: _____

LIFEFLIGHT OF MAINE

CONSENT FOR TREATMENT AND TRANSPORT

LifeFlight of Maine, LLC
Tax ID: 01-0518516
LOM RC#: _____

I have been advised of and consented to all treatment and transport rendered to me or my dependents by LifeFlight of Maine. I am ultimately responsible for payment for this service including any deductible, coinsurance, or non-covered services. I acknowledge that I am legally responsible for payment for the ambulance services provided to me. I request that payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to LifeFlight of Maine for any services furnished to me by LifeFlight of Maine, whether in the past, now, or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as LifeFlight of Maine, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now or in the future. I acknowledge that I have been offered a copy of the notice of LifeFlight of Maine privacy practices. I give permission for LifeFlight of Maine and its agents to disclose to any appropriate insurance carrier and its contracted review organization, and to other persons who may become legally obligated to pay all or part of my treatment and transportation bill any information concerning my condition and treatment as reasonably necessary to provide payors with enough information to allow them to pay for that part of my treatment for which they are obligated. I give permission to LifeFlight of Maine and its agents to release financial, medical and other information about me in written or electronic form to appropriate physicians, healthcare facilities, follow-up entities, and prehospital providers to the extent reasonably required for quality review, reimbursement and in order to assist me to secure continuity of care consistent with Maine law and provisions listed CFR 45 164.520, the Health Information Privacy & Protection Act (HIPAA). I authorize any healthcare provider participating in my care to release such information to LifeFlight of Maine. To the extent information has not been already released, I can revoke all or part of this consent at any time by providing notice in writing. I understand that any refusal to release information or revocation of this consent may result improper diagnosis or treatment, denial of health insurance or other benefits, or other adverse consequences. I understand that I may review my record prior to release and refuse disclosure of any part or all of the record. I permit a copy of this authorization to be used in place of the original. I understand that I am entitled to a copy of this form.

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 must 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. (May be obtained on back of this form)

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.

X _____ _____ _____
Representative Signature Date Printed Name of Representative

_____
Representative's Address

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. Transport 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 pt incapable of signing: _____

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

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

B. Receiving Facility Representative (A hospital form indicating ambulance transport may be used in lieu of 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