Transport Forms

Please fill out the attached forms and include ALL RECORDS with this packet. Please return to your Mercy Health - Life Flight Network LLC crew member.

Check List

- Consent form
    - Section 1 (Patient signature)
    - Section 2 (Physician or RN signature)
- Certificate of Necessity - Complete in entirety
- Face sheet / Demographic Information
- Transport Diagnosis(es)
- Physician HPI
- Medication Administration Record x24 hours
- Allergies
- Nurses Notes x 24 hours
-

If you have questions or need additional packets for transport call 1-800-241-5433

Mercy Health - Life Flight Network,LLC

1402 Lagrange Street

Toledo, OH 43608

MERCYHEALTH
Life Flight Network
Air & Ground

camts
Commission on Accreditation of Medical Transport Systems

Patient Transportation Guidelines

The following are guidelines for the type of patient that may be appropriate for critical care transport. These are only guidelines and other medical conditions may also constitute an intensive care transport. Ultimately, the decision for transport is the responsibility of the referring physician. However, transport nursing staff should be knowledgeable of appropriate transfer conditions and play an active role to facilitate continuity of care in an intensive care environment.

CARDIAC

Cardiac emergencies (ACS)
Unstable arrhythmias
Acute MI requiring PCI
Acute aneurysm
Invasive monitoring (Art line, CVP, swan)
Cardiac medications requiring specialized care
Ventilated patients
Intra-Aortic Balloon Pump

OBSTETRICS

Preterm labor
PROM
Incompetant cervix
Preeclampsia/eclampsia
Placenta Previa
Tocolytic administration
Multiple gestations

TRAUMA

Level 1 trauma care
Multiple internal injury
Hemodynamic instability
GCS decrease
Congenital heart disease
Cardiac contusions with resulting arrhythmias
Pelvic fracture, femur fracture, flail chest
Extensive medication or blood products
Ventilated mechanically

BURN

Degree of burn/percent of burn
Inhalation
Debridement

PEDIATRIC

Trauma level 1
Seizure activity
Overdose
Congenital heart disease
Invasive monitoring (CVP, Art line, swan)
Hemodynamically unstable
Respiratory Compromise
Near drowning

NEURO

Neurological emergencies
Cerebral bleed
Acute tumor situations
Trauma/fracture
Decreased LOC/GCS
Acute cerebral infarct
Aneurysm
Increased ICP

OTHER

Acute Respiratory Failure
Renal/metabolic crisis
Septic shock
Transplant candidates
Acute Vascular Occlusion

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Consent for Treatment and Transportation

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Patient Name: _____ **Transport Date:** _____

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that **Mercy Health – Life Flight Network** provided a copy of its 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 **Mercy Health – Life Flight Network** 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 **Mercy Health – Life Flight Network** 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 **Mercy Health – Life Flight Network** 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 **Mercy Health – Life Flight Network.** I authorize **Mercy Health – Life Flight Network** 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 **Mercy Health – Life Flight Network** 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 **Mercy Health – Life Flight Network**, now, in the past, or in the future. I also authorize **Mercy Health – Life Flight Network** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information. I have been advised of and consented to all treatment and transport rendered to me or my dependents by **Mercy Health - Life Flight Network.**

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

X_____ _____ X_____ _____
Patient Signature or Mark | Date | Witness Signature | Date

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 **Mercy Health – Life Flight Network** now or 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
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ 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 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.

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

Name and Location of Receiving Facility: _____ Time: _____

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Mercy Health – Life Flight Network.**

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 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

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Receiving Facility Representative | Date | Printed Name and Title of Receiving Facility Representative

Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR NON-EMERGENCY TRANSPORTATION BY GROUND AMBULANCE

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*	

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)* Mercy Health - Life Flight Network, LLC	
5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI) — *10 Digits* 1033705934

Certification

7. Criteria *(Mark each reason why transport is being certified as necessary for this individual.)*	8. Period Beginning Date *(Enter the first date of the certification period.)*
During transport, this individual requires: ☐ medical treatment or continuous supervision by an EMT. ☐ the administration or regulation of oxygen by another person. ☐ supervised protective restraint.	9. Length *(Mark <u>one</u> box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)* ☐ Not more than day(s) ☐ One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*	
12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*	

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.