LIFE FLIGHT/MOBILE LIFE
CERTIFICATION OF TRANSPORT

PATIENT NAME: _____Date: _____
REFERRING PHYSICIAN: _____
REFERRING HOSPITAL: _____
DIAGNOSIS: _____
DESTINATION: _____

REASON FOR TX

TRANSFER TO ANOTHER FACILITY IS NECESSARY DUE TO THE FOLLOWING SPECIALIZED SERVICE NOT AVAILABLE AT REFERRING HOSPITAL: (please check all that apply) SECTION 1

___ Level I/II trauma care.
___ Tertiary level cardiac critical care
___ Tertiary level vascular surgery
___ Neurology/neurosurgery
___ OTHER_____
___ High risk obstetrical/neonatal services
___ Tertiary respiratory critical care
___ Pediatric intensive care
___ Tertiary Medical/Surgical Intensive Care

*******SECTION 1 & 2**
NEED TO BE COMPLETED BY THE REFERRING PHYSICIAN OR REFERRING RN

MODE OF TRANSPORT

This patient is discharged from this hospital and is to be transported to the above noted receiving facility by: SECTION 2

***MOBILE INTENSIVE CARE UNIT* (MICU)** *due to: (please check below)*
___ Patient has potentially life/limb threatening injuries and requires critical care transport to a trauma center
___ Level of care is critical. Patient's acuity is such that the continued assessment and interventions of a transport RN may be required to prevent complications and/or death.
___ Other: _____

LIFE FLIGHT HELICOPTER *due to: (please check below)*
___ **TIME FACTOR IS CRITICAL.** Patient requires immediate treatment at a tertiary care center and may potentially be compromised by ground transport.
___ **Level of Care is Critical.** Patient's acuity is such that the continued assessment and interventions of a physician and/or RN may be required to prevent complications and/or death. Transport by any other means may compromise the patient.
____ **OTHER**_____

X_____X_____
PHYSICIAN PRINTED NAME **PHYSICIAN SIGNATURE OR V/O WITH REF. RN SIGNATURE**

LIFEFLIGHT/MOBILE LIFE
Please read and sign where indicated:

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 for payment to Medicare, Medicaid, or any other payor for any services provided to me by LIFEFLIGHT /MOBILE now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by LIFEFLIGHT/MOBILE, 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 LIFEFLIGHT/MOBILE 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 LIFEFLIGHT/MOBILE. I authorize LIFEFLIGHT/MOBILE to appeal payment denials or other adverse decisions or other adverse decisions on my behalf without further authorization. I authorize LIFEFLIGHT/MOBILE to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors 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 LIFEFLIGHT/MOBILE, now, in the past, or in the future.

X_____ _____ X_____
Patient Name (PRINTED) Patient Signature Date
***IF THE PATIENT SIGNS WITH AN "X" OR OTHER MARK, A WITNESS SHOULD SIGN BELOW

If form is signed by a personal representative, please indicate relationship to patient: _____