AIR AMBULANCE & COMMERCIAL MEDICAL ESCORT SERVICES

Medical Necessity Form

Patient Name _____ DOB _____ SS# _____

Diagnosis _____ ICD-10 Codes _____

Sending Facility _____ Receiving Facility _____

Patient requires Aero Medical transport for the following reasons (Check all that apply)

Justification

☐ Patient is being transferred at the request of the attending Physician from a facility with inadequate capabilities for the patient's needs to an appropriate facility that can meet the patient's needs.
Specify _____

☐ Patient is being transported for intervention/test not available at the referring facility.

☐ Patient is being transported due to a change in level of care.

☐ Patient requires therapeutic regiment to be initiated within limited time frame

☐ Patient is being transported home after medically necessary intervention at an appropriate facility
Time of transfer between facilities must be minimized

☐ Other- Specify _____

Level of Care

☐ Patient requires Critical Care/Specialty Care interfaculty transport with at least one Critical Care Registered
Nurse and Certified Paramedic in transport. Patient requires continuous care, monitoring, medication, and or procedures normally and customarily provided in a hospital specialty, intensive, coronary or critical care unit.

☐ Patient requires **Advanced Life Support Care** and treatment during interfaculty transport, including basic and intermediate life support, which may be performed by a Registered Nurse and Certified Paramedic operation under medical direction.

☐ Patient requires **Basic Life Support Care** and treatment during interfaculty transport, including basic and intermediate life support, which may be performed by a Registered Nurse and Certified Paramedic operating under medical direction.

Required Doctor Statement for Medical Necessity:

Provider Signature_____ Title _____ Date: _____

Please fax this completed form to 877-773-0155