Need an Air Ambulance?

✓ **Medical / Surgical**	✓ **Psychiatric**
✓ **Cardiac**	✓ **Rehabilitation**
✓ **Trauma**	✓ **Pediatric**
✓ **High Risk OB**	✓ **Critical Care**
✓ **Neuro**	✓ **Burn Patients**
✓ **Infants > 28 days / 5kg or > 10kg for ventilated patients. < 28 days for stable feeders / growers on a case by case basis**	

CSI is equipped with the latest technology and equipment as well as a highly trained critical care nurse, paramedic, and two pilots on every flight.

CSI never engages in balance billing. We work with insurance companies to provide in-network rates and protect patients both medically and financially.

For transport or more information, call below:

P: 1-833-I Fly CSI (435-9274)

F: 1-866-223-1141

FLIGHT REQUEST 1-833-I Fly CSI (435-9274)

FAX 1-866-223-1141

www.csiaviation.com

Transfer Information

- ☐ Signed Medical Necessity Form
- ☐ Patient Age & Weight
- ☐ Names of Sending & Receiving Physicians
- ☐ Diagnosis
- ☐ 2 Copies of Patient Face Sheet
- ☐ Signed EMTALA Form from Sending Facility
- ☐ Signed CSI HIPPA/Consent Form
- ☐ Copies of Films/CT/MRI/X-Rays
- ☐ Copies of Lab Results
- ☐ Copy of Chart for Receiving Facility

Preparation for Flight

- ☐ IV Access (2 sites preferred)
- ☐ Airway Control (consider early intubation)
- ☐ NG / OG Tube
- ☐ Foley Catheter
- ☐ Chest Tube (if indicated)
- ☐ Wound Dressing / Splints
- ☐ Blood Products (if indicated)

Place patient transfer documents in envelope and send with CSI Flight Crew

For additional forms and leaving feedback, scan QR code below

Feedback@csiaviation.com

PATIENT CONSENT FORM

Transfer Request 1-833-I Fly CSI (435-9274) Fax 1-866-223-1141

Patient Name:______________________ **Flight #**______________ **Transport Date:**______________

I hereby consent to critical care transport and all necessary medications, treatments, and procedures administered by CSI Aviation, Inc. (CSI).
Privacy Practices Acknowledgment: by signing below, the signer acknowledges that CSI 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 this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by CSI now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financiallly responsible for the services and supplies provided to me by CSI, 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 CSI 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 CSI. I authorize CSI to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to CSI 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 CSI now, in the past, or in the future. I also authorize CSI to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

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.

On the line below, explain 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 CSI now or in the past, (or in the future, when permitted). 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.

A. **Ambulance Crew Member Statement (*must* be completed by crew member at the time of transport) Use this section if the patient is unable to sign and there is no authorized representative available.**
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. 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 CSI. **My signature is not an acceptance of financial responsibility for the services rendered.**

i. On the line below, explain the circumstances that make it impractical for the patient to sign:

____

Name and Location of Receiving Facility: ______________________________

Time at Receiving Facility: ______________

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 above. 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 CSI. 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 Crewmember

PHYSICIAN CERTIFICATION STATEMENT

Transfer Request 1-833-I Fly CSI (435-9274) FAX 1-866-223-1141

Flt#:____________ **Patient Name:**____________________________ **Date of Service:**___________

Referring Physician: _______________________ **Receiving Physician:** _________________________

Sending Facility:___________________________**Receiving Facility:** ___________________________

	PLEASE CHECK ALL THAT APPLY TO THE PATIENT:
	Acute Neurological emergencies requiring emergent/time sensitive interventions not available at the sending facility
	Acute vascular emergencies requiring urgent/time sensitive interventions not available at sending facilities
	Acute surgical emergencies requiring urgent/time sensitive interventions not available at sending facilities
	Critically ill patients with compromised hemodynamic/ respiratory function who require intensive care during transport
	Critically ill obstetric patients who require intensive care during transport between facilities and where times of transfer between facilities must be minimized to prevent patient/fetal morbidity
	Acute cardiac emergencies requiring emergent/time sensitive interventions not available at the sending facility
	Critically ill neonatal/pediatric patients with potentially compromised hemodynamic/respiratory function, a metabolic acidosis greater than 2 hours post delivery, sepsis, or meningitis
	Patients with electrolyte disturbances and toxic exposure requiring immediate life-saving intervention
	Transplant patients
	Patients requiring care in specialty center not available at the sending facility
	Conditions requiring treatment in a hyperbaric oxygen unit
	Burns requiring treatment in a burn treatment center
	Potentially life- or limb-threatening trauma requiring treatment at a trauma center, including penetrating eye injuries
	EMTALA physician certified interfacility transfer (not a patient request)
	Other (explain):
	PLEASE CHECK ALL THAT APPLY TO THE RECEIVING HOSPITAL:
	The patient is being transferred to this hospital because:
	Closest appropriate facility for the level of care needed for this patient
	Closer appropriate facilities have no beds available
	Closer appropriate facilities have no specialties services available for this patient's care at this time
	Closer facilities have no specialty services available
	Ground Transport time too long for patient's condition to the closest appropriate facility
	Ground Transport not appropriate or unavailable for level of care required during transport
	Weather does not allow for transport to the closest facility
	Other (explain) :

Additional Orders: ____

____

Sending Physician:____
(Signature of sending physician)