AIRLIFT NORTHWEST
UW Medicine

CERTIFICATE OF MEDICAL NECESSITY

Patient Name	DOS
Flight Number	DOB

Instructions:
This form must be completed and signed by referring provider or designee prior to inter-facility transport.

Please fax this form with the face sheet and large patient form if applicable to 206-767-4639.

THANK YOU

1. **This patient requires transfer to a different facility due to:**
   - ☐ Patient requires a higher level of care which is: _____
   - ☐ Patient requires service or therapy to treat their condition which is not available at the referring.
   - ☐ The service or therapy is: _____
   - ☐ Other (please describe) _____

2. **There is a clinical benefit to the time saved by transporting the patient by air: (check all that apply)**
   - ☐ Long Distance: patient's condition requires rapid transportation over a long distance
   - ☐ Pick up point is not accessible by ground transportation
   - ☐ Unstable patient with need to minimize out-of-hospital time
   - ☐ Traffic patterns preclude ground transport at the time the response is required
   - ☐ Other (please describe) _____

3. **Closest Appropriate Facility:**
   Medicare/Medicaid and Federal Employee Insurance Programs mandate air ambulance services to the closest appropriate facility able to provide needed services. If bypassing closest facility, please state reason.
   - ☐ No other closer facility exists ☐ Patient or family request*

   Facility: _____ is unable to accept patient due to:
   - ☐ Specialist: _____ is unable to accept patient
   - ☐ Diversion; no beds/nursing staff
   - ☐ No specialist available; particular service is not available at the time of transport
   - ☐ Other (specify) _____

**Please note that Medicare/Medicaid & Federal Employee Program does not cover transport beyond the closest facility because the patient and/or family prefer a specific hospital or physician, or to maintain a continuity of care due to patient convenience unless there is medical justification or whether or not such an advantage exists.*

4. **If the closest facility is being bypassed, has the patient been advised that he or she may be responsible for additional mileage beyond the closest facility**? ☐Yes ☐No ☐N/A

I certify I have completed this report based upon the information available at the time of the transport request.

Referring Provider or Designee	Print Name	Date