Dispatch: 800-232-0911

Fax: 888-489-8991

## CERTIFICATE OF MEDICAL NECESSITY (CMN)

**LIFE FLIGHT** 

NETWORK

| SECTION I TO BE COMPLETED BY FLIGHT CREW   |   |
|--|---|
| Flight #:  |   |
| Patient Name:  | Transport Date:   |
| Sending Physician:   | Receiving Physician:  |
| Sending Hospital:  | Receiving Hospital:   |
| Sending MRN#:  | Receiving MRN#:   |
| SECTION II TO BE COMPLETED BY SENDING PHYSICIAN Check All That Apply   |   |
|  |   |
| Reason for air medical transport   |   |
| EMTALA certified interfacility transfer to capable appropriate facility – higher level of care.  |   |
| Sending Hospital does not have adequate facilities / equipment / physician specialist to provide medical services needed by this patient. Burn   |   |
| <ul> <li>Unit, Emergent, Cath Lab, PICU, Trauma Unit, Explain:</li> <li>Medical necessity is met such that any other mode of transport is contraindicated and poses a threat to the patient's survival or seriously</li> </ul> |   |
| endangers their health.  |   |
| <ul> <li>Patient requires rapid air and/or ground transport for time sensitiv</li> </ul>   | e emergency, time dependent diagnosis i.e., IV Meds / Advanced                    |
| Procedures.  |   |
| Higher level of care required during transport beyond the scope of available ground ambulance providers:   |   |
| Duration of ground transport would be excessive and detrimental to patient (>30 to 60 minutes) hours minutes   |   |
| Obstacles render the patient inaccessible to ground transport.   |   |
| □ Weather  |   |
| Road/Traffic Conditions  |   |
| □ Disaster   |   |
| Ground transport is unavailable locally.   |   |
| A closer facility has been contacted but does not have available space, qualified personnel or the capacity to assume care of this patient.  |   |
| CLINICAL CONDITIONS CHECKED BELOW REQUIRE TIME SENSITIVE SURGICAL/ MEDICAL INTERVENTION/ MEDICAL MANAGEMENT  |   |
| Unstable or potentially unstable airway  | Neurological emergency:   |
| <ul> <li>Marked respiratory distress / obstructive disorder.</li> </ul>  | <ul> <li>Penetrating / Blunt trauma to Head / Neck / Chest / Abdomen /</li> </ul> |
| <ul> <li>Acute cardiac shock / insufficiency</li> </ul>  | Pelvis  |
| <ul> <li>OB-GYN / NICU Emergency</li> </ul>  | Extremity amputation / limb threatening / degloving / crush                       |
| Significant Burns  | injury.   |
|  | Multiple system trauma i.e., long bone fractures, injury > two                    |
|  | body regions  |
|  | □ Other:  |
| SECTION III TO BE COMPLETED BY SENDING PHYSICIAN   |   |
| Pursuant to Federal COBRA / EMTALA Statute SEC. 1867 [42 U.S.C. 1395dd] (A) Social Security Act – Medical Screening requirement(s) the patient   |   |
| cannot be transferred unless all of the following conditions have been met.  |   |
| A. The receiving facility has available space, qualified personnel, and has the  |   |
| B. Copies of medical records referring to this patient incident will be provide  |   |
| C. I hereby certify the above listed diagnosis, condition(s), and or physical of   |   |
|  | uest for Air Medical Transfer, medical benefits reasonably expected from the      |
| provision of appropriate medical treatment at the receiving hospital out   | weigns the risks, if any, to the patient's condition.                             |
| CHECK ONE:   | □ PA  |
|  | □ PA<br>□ NP  |
|  |   |
|  |   |
| SIGNATURE: DATE: PRINT NAME: DATE: DATE:   |   |
|  |   |