## 5H19213CLAIM808700858 371921361231

AUTHORIZATION AND CONSENT  PATIENT NAME: AULTUTER  UNIT/BASE LD.: LEVER  Date Of Service: 7-13-16  TIME: 17/10. (Military Permat)  CONSENT TO TREATMENT. I scoop from Air Michado Corp., its agents and any of its associated complaints (sogether, "Provider"), a medical transportation and medical services, administration of medical care since and provider makes no guarantees below my health outcome.  RELEASE OF INFORMATION.  RELEASE OF INFORMATION.  Received the provider to othere may part of my medical receives estimated by frowler, and on in the future, to any other information necessary for billing agent (sopether, "Insurer"). I agree to allow provider to othere may part of my medical receive on refless to Provider or Insurer any information necessary for billing agent (sopether, "Insurer"). I agree to allow any owney ow with medical and billing information about me or refease to Provider or Insurer any information necessary for billing and payment purposes. Agree a copy of this form may be used instead of the original.  ASSIGNMENT of BRENETIS & RECHES 1 agree to allow and receive a clump and receive delivered now or in the future. I assign to Provider all of my rights and interest in all such insurance benefits or proceeds for services delivered now or in the future. I assign to Provider all of my rights and interest in all such insurance benefits or proceeds for services delivered by Provider; including the rights to: (1) repeated are receive any documents or information from any entity or person including those governed by the Employee Retiremen Income Security Act of 1974 (PRISAT). It of the full extent of my rights; (2) appeal any expendent insurance is a converged; (2) please any type and receive any documents or information from any insurance or information from any insurance or information and in any the provider with a my services or to receive the provider in maximize payment of my insurance benefits and minimization or receive the provider in maximize the complete to the provider and subject to the pr					_
ECTION 19 PATIENT NAME: ALCALIBERT   Date Of Service   7-13-19   TIME:   Discussion   (Military Format)  CONSENT TO TREATMENT:   accept from Air Methods Corp., its agents and any of its associated complaces (logether. Provider") air medical transportation and medical curvices, administration of medical corporations of medical procedures ("Services") performed by the company listed above and any agent or entity acting on behalf of that company (collectively, "Provider"). I understand that medical care is not a exact circinc and Provider makes no guarantees about my health outcome.  RELEASE OF INFORMATION.   agree to allow Provider to share any part of my medical record or other information needed for billing and payment proproses.   agree a contrares, health or liability insurers, and any drive insurance organization or billing agent (together, "Insurer"). I agree to allow anyole with medical and billing information about me to release to Provider or Insurer any information about me to release to Provider or Insurer any information about me to release to Provider or Insurer any information about me to release to Provider or Insurer any information about me to release to Provider or Insurer any information about me to release to Provider or Insurer any information about me to release to Provider or Insurer any information about me to release to Provider or Insurers or Insurers and information in the full amount of the proceeds of Provider's entires, or Insurers in all such insurance benefits or procedes for services delivered by Provider, including the rights to: (1) request and receive any documents or information from language the full amount of the procedure of the organization or received for services delivered by Provider, including the rights to: (1) request and receive any documents or information form may meet the full and the fu	AirMeth	ods' AUTHO	RIZATION AND CONS	REN'T	
UNIT/BASE LD.: COAD Date Of Servie: 7-15-15 TIME: 1	SECTION I		ALLON AND CONTRACTOR OF THE PARTY OF THE PAR	22112	
CONSENT TO TREATMENT.  medical transportation and medical  crystrices") performed by the company listed above and any agent or entity acting on obtain of that company is company listed open and the performed by the company listed above and any agent or entity acting on obtain of that company is company listed open and the performed by the company listed observed and agent or entity acting on obtain of that company is company listed observed and provider makes no guarantees about my health outcome.  RELEASE OF INFORMATION.  Regret to allow Provider to share only part of that company for that company listed of the original of the performance of the perf			e: 7-13-19 TIME	: 17/0	(Military Format)
payment for services delivered by flovider, now or in the fature, to any financially responsible party, including: the Centers for Medicare and Medicaid Services (CMS), their agiasts, Worke's Compensation carriers, health or liability injuriers, and any dubter insurance organization or billing agent (together, "Insurer"). I agree to allow anyone with medical and billing information about me to release to Provider or Insurer any information about mesosary for billing and payment purposes.  ASSIGNMENT OF BENEFITS & RIGHTS. I agree to allow anyone with medical and billing information about me to release to Provider or Insurer any information about me to release to Provider or Insurer any information from the fature of the proceeds of my benefits up to the full amount of Provider's charges for services delivered now or in the future. I assign to Provider all of my rights and interest in all such insurance benefits or proceeds for services delivered now or in the future. I assign to Provider and receive any documents or information from any entity or person, including those governed by the Employee Reitmenn, Insome Security Act of 1974 ("REISA"), to the full extent of my rights; (2) appeal any decidal or underspanned to benefits or coverage; (3) persons any forum and get all available rolled (monclary or equitable), including applying all ERISA provisions. These rights assigned to Provider are assigned completely, without any limitations or reservations.  FINANCIAL RESPONSIBILITY my personal financial responsibility I agree to allow Provider to the maximize payment of my impairs (2) agree to allow Provider to maximize payment of my insurance benefits and minimize my personal financial responsibility I agree to allow Provider to the analysis of the presence of the provider.  FINANCIAL RESPONSIBILITY my personal financial responsibility I agree to allow Provider to be my advocate throughout the billing process to help resolve my claim as quickly as possible. If I receive payment from an Insurior for Provider's service	CONSENT TO TREATMENT, I medical transportation and medica ("Services") performed by the com-	accept from Air Mo l services, administ pany listed above ar	thods Corp., its agents and any of it ation of medications and blood or d any agent or entity acting on beh	ts associated comp r blood products, alf of that compar	anies (together, "Provider") air and other medical procedures
the proceeds of my bensfits up to the full amount of Provider's charges for services delivered now or in the future', lassing to Provider all of my rights and interest in all such insurance benefits or proceeds for services delivered by Provider, including the rights to: (1) request and receive any documents or information from any entity or person including those governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), to the full extent of my rights (2) appeal any denial or underpayment of benefits or coverage; (3) piezuse any legal remedies in any forum and get all available relief (thonclary or equitable), including applying all ERISA provisions. These rights assigned to Provider are assigned completely, without any limitations or reservations.  FINANCIAL RESPONSIBILITY  I will cooperate with any personal financial responsibility [1] agree to allow Previder to be my advocate throughout the billing process to help resolve my claim as quickly as possible. If I receive payment from an Insulor for Provider: a throughout the billing process to help resolve my claim as quickly as possible. If I receive payment from an Insulor for Provider's services, I agree to prompily send such payment to Provider. In understand that many Insurers will play pay for service that mederate coverage requirements, such a medical necessity. If my Insurer denies or underpays Provider's charges for any reason, or [1] have no insurance, J accept direct financial responsibility for any unpaid charges.  COLLECTIONS & TELEPHONE CONSENT. I agree to allow Provider to: (1) use pre-recorded or artificial voice messages, or an automatic telephone dialling system, to contact me at the relephone number provider below, which may be a wireless or cell phone number; (2) leave answering machine or voice mail messages for me, and include in any such messages information required by law (including debt collection laws) or other information about announts I over; (3) send text messages or e-mails to the telephone number; (2) leave the	payment for services delivered by F Medicaid Services (CMS), their ag- billing agent (together, "Insurer"). I	rovider, now or in the sts, Worker's Comp agree to allow anyor	e future, to any financially responsib ensation carriers, health or liability e with medical and billing informati	ole party, including insurers, and any c ion about me to rel	the Centers for Medicare and other insurance organization or case to Provider or Insurer any
my personal financial responsibility I agree to allow Provider to be my advocate throughout the billing process to help resolve my claim as quickly as possible. If I receive payment from an Insurer for Provider's services, I agree to promptly send such payment to Provider. I may not provider a service that meet certain coverage requirements, such as implicial necessity. If my Insurer denies or underpays Provider's charges for any reason, or I have no insurance, I accept direct financial responsibility for any unpaid charges.  COLLECTIONS & TELEPHONE CONSENT. I agree to allow Provider to: (I) use pre-recorded or artificial voice messages, or an automatic telephone dialing system, to contact me at the telephone number provided below, which may be a wireless or cell phone number; (2) leave answering machine or voice mail messages for me, and include in any such messages information required by law (including ded collection laws) or other information about amounts I owe; (3) send text messages or e-mails to the telephone number and e-mail address provided below about unpaid balances or other billing issues. I also agree to allow Provider to get a credit report to help collect unpaid balances.  I have read this information and J any the patient, the patient, is legal representative or authorized by the patient as the patient as agent to sign this first Authorization and Consent form and to accept its terms. This Authorization and Consent form contains the complete agreement and any handwritten words or other changes to the typewritten text are invalid and non-enforceable. Changes can only be imade by a separate agreement signed by me and Provider.  SECTION III  Mark the Apprepriate Box and Sign Bellow:  Signature of Crew t patient signs using an "X"  Witness Signature (if patient signs with an "X")  A Legal Guardian B (Reciptor of George Patient) to the Patient (see back for definition):  A Company Guardian B (Reciptor of George Patient) and consent form and to see patient of the patient signs with an "X")  A Compan	the proceeds of my benefits up to the rights and interest in all such insura any documents or information from ("ERISA"), to the full extent of my forum and get all available relief (	full amount of Province benefits or proce any entity or person ights; (2) appeal any nonetary or equitabl	der's charges for services delivered a ds for services delivered by Provide including those governed by the En denial or underpayment of benefits c), including applying all ERISA p	now or in the future er, including the rig nployee Retirement or coverage; (3) pu	. I assign to Provider all of my hts to: (1) request and receive Income Security Act of 1974 rsue any legal remedies in any
automatic telephone dialing system, to contact me at the telephone number provided below, which may be a wireless or cell phone number; (2) leave answering machine or voice mail messages for me, and include in any such messages information required by law (including debt collection laws) or other information about amounts I ove; (3) send text messages or e-mails to the telephone number and e-mail address provided below about unpaid balances or other billing issues. I also agree to allow Provider to get a credit report to help collect unpaid balances.  I have read this information and I am the patient, the patient's legal representative or authorized by the patient as the patient's agent to sign this this Authorization and Consent form and to accept its terms. This Authorization and Consent form contains the complete agreement are invalid and non-enforceable. Changes can only be made by a separate agreement signed by me and Provider.  SECTION II  Mark the Appropriate Box and Sign Below:  Signer below is the Spatient Authorized Representative see Back for behaldon Crew Member (NO Representative was available or willing to sign)  Mitness Signature; (If patient signs with an "X")  Signature of Crew i patient signs using an "X" Witness Signature; (If patient signs with an "X")  A (Legal Guardian) B (Recipient of Government Benefits for patient in Concept and Consent form contains the complete agreement in D Concept and Consent form contains the complete agreement signs with an "X")  Patient unable to sign (check box, if appropriate and explicit below):  Patient unable to sign (check box, if appropriate and explicit below):  Patient unable to sign (check box, if appropriate and explicit below):  Patient unable to sign (check box, if appropriate and explicit below):  Patient unable to sign (check box, if appropriate and explicit below):  Patient unable to sign (check box, if appropriate and explicit below):	my personal financial responsibility quickly as possible. If I receive pa understand that many Insurers will	I agree to allow Pro yment from an Insu- only pay for service:	vider to be my advocate throughou or for Provider's services, I agree that meet certain coverage require	t the billing proces to promptly send ments, such as me	s to help resolve my claim as such payment to Provider. I dical necessity. If my Insurer
this Authorization and Consent form and to accept its terms. This Authorization and Consent form contains the complete agreement and any handwritten words or other changes to the typewritten text are invalid and non-enforceable. Changes can only be made by a separate agreement signed by me and Provider.  SECTION II  Mark the Appropriate Box and Sign Below:  See Back for Deflation  Signature of Crew 1 patient signs using an "X" below in the Signer, UNLESS SIGNER IS SPOUSE, PARENT OF  Signature of Crew 1 patient signs using an "X" below in the Signer, UNLESS SIGNER IS SPOUSE, PARENT OF  Signature of Crew 1 patient signs using an "X" below in the Signer, UNLESS Signature (if patient signs with an "X")  A (Lega) Guardian) B (Recipient of Government Benefits for patient) C (Spouse, Parent, or person responsible for patient) a stales)  Patient unable to sign (check box, if appropriate and explain below):  PECIFIC MEDICAL, MENTAL or L EGAL (e.g. minor or pelsoner) REASON PATIENT UNABLE TO SIGN  SECTION IV  RECEIVING FACILITY ACKNOWLEDGMENT	automatic telephone dialing system, leave answering machine or voice collection laws) or other information	o contact me at the t nail messages for m n about amounts I o	lephone number provided below, w e, and include in any such messag ve; (3) send text messages or e-ma	hich may be a wire es information req ils to the telephon	less or cell phone number; (2) uired by law (including debt e number and e-mail address
Signature of Crew i patient signs using an "X" by Section III witness Signature of Grew i patient signs using an "X" by Witness Signature of Grew i patient signs using an "X" by Witness Signature of Grew i patient signs using an "X" by Witness Signature of III witness Signature of Grew i patient (see back for definition):  A (Lega) Guardian   B (Recipient of Greenment Benefits for patient   C (Spunge, Parent, or person responsible for patient's affairs)   D (Agency Rep that provided service o patient)  Patient unable to sign (check box, if appropriate and explain below):  PECIFIC MEDICAL, MENTAL or LEGAL (e.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN  ECCTION IV RECEIVING FACILITY ACKNOWLEDGMENT	this Authorization and Consent form handwritten words or other changes t	and to accept its ter	ns. This Authorization and Consent	form contains the	complete agreement and any
Signature of Crew is patient signs using an "X" Witness Signature (if patient signs with an "X")  A (Lega) Guardian)  B (Recipion of Government Benefits for patient   D C (Spouse, Pagen), or person responsible for patient's offairs) D (Agency Rep that provided service o patient)  Patient unable to sign (check box, if appropriate and explain below):  PECIFIC MEDICAL, MENTAL, or LEGAL (e.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN  SECTION IV  RECEIVING FACILITY ACKNOWLEDGMENT				r (NO Representative s	ras available or willing to sign)
Witness Signature (if patient signs with an "X")  A (Legal Guardian) B (Recipient of Government Benefits for patient) C (Spause, Parent, or person responsible for patient's offsies) D (Agency Rep that provided service o patient)  Patient unable to sign (check box, if appropriate and explain below):  PECIFIC MEDICAL, MENTAL, or LEGAL (e.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN  RECEIVING FACILITY ACKNOWLEDGMENT				he signer, UNLESS SIG	NER IS SPOUSE, PARENT OF
A Authorized Representative, identify relationship to the Patient (see back for definition):  A (Legal Guardian)  B (Recipient of Government Benefits for patient)  C (Spause, Parent, or person responsible for patient's affairs)  D (Agency Rep that provided service o patient)  Patient unable to sign (check box, if appropriate and explicit below):  PECIFIC MEDICAL, MENTAL, or LEGAL (e.g. minor or pelsoner) REASON PATIENT UNABLE TO SIGN  SECTION IV RECEIVING FACILITY ACKNOWLEDGMENT		Signature of Crew i	patient signs using an "X" 🏲 🏲		
A (Lega) Guardian)  B (Recipion of Government Benefits for patient)  C (Spause, Farent, or person responsible for patient's offairs)  D (Agency Rep that provided service opatient)  Patient unable to sign (check box, if appropriate and expli in below):  PECIFIC MEDICAL, MENTAL, or LEGAL (e.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN  SECTION IV  RECEIVING FACILITY ACKNOWLEDGMENT	SECTION III	elationship to the Pati	nt (see back for definition):	Witness Signature	(If patient signs with an "X")
Patient unable to sign (check box, if appropriate and explain below):  PECIFIC MEDICAL, MENTAL, or LEGAL (e.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN  ECTION IV RECEIVING FACILITY ACKNOWLEDGMENT	A (Lega) Guardian) D B (Recipient of Go		I.	for patient's offairs)	D (Agency Rep that provided service
PECIFIC MEDICAL, MENTAL, or LEGAL (c.g. minor or prisoner) REASON PATIENT UNABLE TO SIGN SECTION IV RECEIVING FACILITY ACKNOWLEDGMENT		appropriate and expl	iń below):		
	PECIFIC MEDICAL, MENTAL. or L	EGAL (e.g. minor or	risoner) REASON PATIENT UNABI	LE TO SIGN	
FACILITY NAME: TREEMANI WEST, CITY: DP4N ST: MD	ECTION IV	RECEIVING FAC	LITY ACKNOWLEDGMEN	T	
	FACILITY NAME: TREEMAN	IWEST.	CITY: DPL	cal	ST: MD

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-	WAIr Method	16.		
PC!	DEFENDERS & TOMORRO	WF		ŧ
Medi	ical Necessity for Air A			099946
Date o	of Service: 7-13-19	Patient Name: A	Diagnosis; MV	C-MOTORINGLE
Presen	ting time-critical condition	required intervention	MVC MOTOR LICE	
6	Ground transport would	have been hazardous	due to the LENGTH OF TRANSPORT. minutes versus air transport time of 20	minutes.
T	he following information	is required for INTE	RFACILITY TRANSPORTS:	
- 1	Patients Name:		Referring physician:	
- 1	eferring hospital:		Receiving physician:	
- 1	ecciving hospital:	C t a premara	Unit Name:	
ــا			tall air transport is needed: YES Not Verified	
sections	y):	1	on is required for the following reasons (mark all that apply	minimum of one from both
SECTI	ON 1 - REASON(S) FOR The patient's condition w	METHOD OF TRA	NSPORT: , requiring rapid air transportation in order to minimize	morbidity / mortality.
<b>E</b>	The patient's condition from the EMS, cardiad tr	uma pediatric, or ne	for transport based on published standards for appropria matal communities.	te utilization of air transport
Ø	During transport, the pating present (specify care): (specify Medications)	nt's condition required TPA in	d critical care life support and monitoring by an ALS critical Care life support and monitoring XEKG XII	ew with an attending RN V Medications, titrated drips
	Unable to leave o	bunty inaccessible by grou	d / or delayed due to: Rush hour / unific condition  Bridge out/road construction  No ground available Other  RSI Blood Product Administration Med	weather conditions
SECTION	ON 2 - REASON(S) PATI	ENT REQUIRED T	RANSPORT:	
Ø	The receiving facility prov	ides specialized care	treatment, and diagnostics not available at referring fi ired and facilities needed) TRAUMA SUEC	cility or a facility that may
	No beds or needed special	ist available at referr	ng facility (describe unit/bed type/specialist not availab	le at referring facility)
	Specialized maternal / ne Other maternal / neonatal s	natal care required v pecialized services n	rith high-risk obstetrician and / or neonatal ICU not ava	ilable at referring facility.
	Specialized Trauma Care referring facility or service	equired with diagnosts s needed for scene tr	ic and trauma surgical facilities readily available. (Descinsport) TRAVMA SURCERY	the services not available at
	LEXITICATION time > 30 m	inutes DCrash speed	C with ejection Head on collision Same vehicle change > 20 mph Pedestrian struck by motor vehicle wo or more proximal extremity fractures Fall 20 > fe	Mariant Patient
	Specialized cardiac care fa candidate Cath Lab at re (Describe specialized card	lerring facility not of	th Lab facility and surgical backup readily available con all hours Cath Lab at referring facility has no surger	High-risk cardiac surgical gical back up
		, , , , ,	The state of the s	