



North Dakota Workforce
Safety & Insurance

**NON-EMERGENT AIR
AMBULANCE FACILITY-TO-
FACILITY REQUEST**

MEDICAL SERVICES DIVISION
SFN 61404 (06/2020)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone Number 701-328-5990
Toll Free Number 888-777-5871
Local Fax 701-328-3765
Toll Free Fax 866-356-6433
TTY Number (hearing impaired) 701-328-3786
www.workforcesafety.com

SECTION 1 – Injured Employee’s information			
Claim number	Injured Employee’s (First name)	(Last name)	Date
Date of injury		Date of birth	
SECTION 2 – Facility requesting air transport			
<input type="checkbox"/> Precertification <input type="checkbox"/> Appeal		Schedule date of transfer	
Person to notify with decision		Preferred method of notification or recommendation <input type="checkbox"/> Telephone call or <input type="checkbox"/> Fax	
Telephone number		Fax number	
Facility name		Facility mailing address	
City		State	ZIP code
Facility telephone number		Facility fax number	
SECTION 3 – Certifying provider information			
Provider’s full name (MD, NP, PA)		Provider’s NPI number	
SECTION 4 – Transport information			
Receiving facility		Receiving physician	
Facility address			
City	State	ZIP code	Facility telephone number
Air ambulance carrier			
SECTION 5 – Reason for medically necessary air transport (check all that apply)			
<input type="checkbox"/> The patient is unstable or potentially unstable <input type="checkbox"/> The patient requires the medical expertise of a flight physician/nurse/paramedic during medical transport <input type="checkbox"/> The patient’s condition warrants minimal out-of-hospital time between critical care units <input type="checkbox"/> The patient requires advanced level treatments, medications, or other interventions, which are above the scope of available ground ambulance transport units <input type="checkbox"/> The extended time of or distance of ground transportation to the nearest appropriate facility is potentially detrimental to the patient <input type="checkbox"/> Other			
SECTION 6 – Certification of preferred carrier			
I certify the patient’s condition requires air ambulance transportation due to time or geographical factors. I further certify that I have reviewed the current list of air ambulance carriers which have an existing Memorandum of Understanding with Workforce Safety & Insurance as cited on www.workforcesafety.com/medical-providers/authorization/ambulance .			
Signature			Date
Printed name			
<input type="checkbox"/> EMT <input type="checkbox"/> Paramedic <input type="checkbox"/> Trained first responder <input type="checkbox"/> Physician <input type="checkbox"/> Physician assistant <input type="checkbox"/> APRN			
Do you (requesting source) have a financial or employment relationship with the ambulance supplier transporting the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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