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*

☐ Precertification ☐ Appeal	Schedule date of transfer
Person to notify with decision	Preferred method of notification or recommendation ☐ Telephone call **or** ☐ 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)*

☐ The patient is unstable or potentially unstable
☐ The patient requires the medical expertise of a flight physician/nurse/paramedic during medical transport
☐ The patient's condition warrants minimal out-of-hospital time between critical care units
☐ The patient requires advanced level treatments, medications, or other interventions, which are above the scope of available ground ambulance transport units
☐ The extended time of or distance of ground transportation to the nearest appropriate facility is potentially detrimental to the patient
☐ 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

☐ EMT ☐ Paramedic ☐ Trained first responder ☐ Physician ☐ Physician assistant ☐ APRN

Do you (requesting source) have a financial or employment relationship with the ambulance supplier transporting the patient?
☐ Yes ☐ No

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