MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS
HEALTH PLAN

Air Ambulance Questionnaire
(Provider)

Participant: ______________________ **SSN:** ______________ **DOS:** _____________

Patient: __________________________________ **Date:** __________________________

1. Was the patient transported to the nearest facility equipped to treat the emergency condition? Yes No
   Transportation was from __________________________ to ___________________________
2. What level of care was needed?
   Basic life support Advanced life support Critical care Specialty care
3. What medical equipment, medications and supplies were utilized?

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4. Are there transportation records documenting clinical care during transport? Yes No
   If yes, please attach a copy of the reports.
5. Were the services provided from bedside to bedside? Yes No
6. Did any family members travel with the patient? Yes No If yes, who? _________________
7. How many medical personnel were on board? _______ Please include certifications and/or license numbers for each in attendance.

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8. Is your company a member of the Association of Air Medical Services? Yes No
9. Are the total charges all-inclusive (i.e., are ground ambulance charges included)? Yes No
10. Are your services licensed by the state and/or country in which you operate? Yes No
11. If your company has a Medical Director, what is his/her name? ___________________________

Questionnaire completed by:

_____________________________ _____________________________ __________
Name (Please print) Signature Date

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Title

Return completed form to the Medical Review Department:
MPIHP, P.O. Box 1999, Studio City, California 91614-0999

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