Air Ambulance Questionnaire
(Patient/Participant)

Participant: ________________________ **SSN:** _______________ **DOS:** ______________

Patient: ____________________________________ **Date:** ____________________________

1. Reason for the air ambulance: ____

2. Was the air ambulance used to transport you to the nearest facility? Yes No
   Ambulance from ______________________________ to _______________________________

3. Do you know the level of care that was needed?

   Basic life support Advanced life support Critical care Specialty care Not known

4. Were the company's services provided from bedside to bedside? Yes No

5. Did any family members travel with the patient? Yes No

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6. How many medical personnel were on board? ____________

7. Are the total charges all-inclusive (i.e., are ground ambulance charges included)? Yes No

Questionnaire completed by:

________________________________ ________________________________ __________
Name (Please print) Signature Date

____
Title

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

Med Rev/AIRMMBR/5/05