Vanderbilt University Medical Center- LifeFlight

Patient's Name: _____ Medicare # (HICN): _____

Trip Report # _____

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.
Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.** When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

Medicare will not pay for-

Items or Services:

_____ Patient's medical condition may not warrant the use of Air ambulance transportation
_____ Mileage is beyond what Medicare considers the nearest appropriate facility
_____ Patient elected to bypass the nearest medical facility.

Because:

_____ Patient's medical condition may not meet the medical necessary criteria for transportation
_____ Patient may be safely transported by another method
_____ Medicare reimburses mileage for air ambulance transports to the nearest appropriate facility
_____ Medicare reimburses ambulance transport to the nearest appropriate facility.

***This is only a general summary of exclusions from Medicare benefits. It is not a legal document.**
The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.
Before you make a decision, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost:_____**).

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE

☐ **Option 1. YES. I want to receive these items or services.**
I understand that my condition and/or requested destination does not meet Medicare's guidelines for air ambulance transport. I understand that I will be financially responsible for the above services.

☐ **Option 2. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____

Date Signature of patient or person acting on patient's behalf

_____

Please print name and relationship to patient

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.