MISSION ID: VETAir00001

AUTH FORM VER 1.0
08 NOV 24

VETAir Inc. SMTAA AUTHORIZATION

SECTION A

	REQUESTOR	SCHEDULE	REQUEST TYPE	AMBUATORY STATUS	CITY FROM	CITY TO
REQUEST						

	NAME	RANK	BRANCH	SVC ERA	LAST 4	DOB	GENDER	DISAB %	SVC CON	VA BENEFIT #
VETERAN										

	POC/POA	NAME	EMAIL	TELEPHONE

	SENDING FACILITY	SENDING POC	NAME	EMAIL	TELEPHONE
FACILITY					

	RECEIVING FACILITY	SENDING POC	NAME	EMAIL	TELEPHONE

VETAir Certifying Official: I the undersigned do verify this is A VALID SMTAA REQUEST

NAME		TITLE		SIGN		DATE	

SECTION B

VETAir Inc. (VETAir) Authorization to coordinate, provide, and bill, for Veterans Administration Special Mode Transportation Air Ambulance (SMTAA) and Health Insurance Portability and Accountability Act (HIPPA) release of information. (45 CFR Parts 160&164)

I hereby authorize VETAir and its agents to contact and coordinate with any and all agents associated with providing SMTAA and / or disclose Protected Health Information (PHI) IAW the following:

	I authorize the release of all PHI										
	I authorize the release of all PHI Except:	Mental Health		HIV/AIDS		Commun Diseases		Drug / Alcohol		Other:	

This Health Information may be used by VETAir and its agents for coordination of SMTAA, medical treatment, consultation, billing/claims, payment, and/or other reasonably related purposes directly related to SMTAA.

This Authorization shall be in force and effect until Date/Event: _____ or death at which time this Authorization expires.

I understand that I have the right to revoke this Authorization, in writing, at any time. I understand that a Revocation is not effective to the extent that any person or entity has already acted in reliance on my Authorization or if my Authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

I understand that information disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Veteran Certifying Official: I the undersigned verify I HAVE THE AUTHORITY TO PROVIDE PHI AND MAKE THIS SMTAA REQUEST

NAME		TITLE		SIGN		DATE	

SECTION C

NOTES	

VETAir Certifying Official: I the undersigned do verify PATIENT CONSENT AND PHI FORMS ARE SIGNED AND VA 2649A IS ATTACHED

NAME		TITLE		SIGN		DATE	

MISSION ID: VETAir00001

SECTION D

SMTAA	MSN TYPE	CITY	ARPT	CITY	ARPT	DISPATCH	SMALL TURBINE FLT HRS	MEDIUM TURBINE FLT HRS	LARGE TURBINE FLT HRS	LIVE MI	GND AMB	OPS
RICO	SAAM											
BOISE	SAAM											
ACUTE AIR	SAAM											
AIRCARE	SAAM											
ATLAS	SAAM											
OPTIMUM	SAAM											
	CHM											
	CHM											
	CHM											
	CHM											
OTHER:	CME											
	CME											
ANG	CME											
					TOTAL	0	0.0	0.0	0.0	0	0	0.0

	DATE	ETD	ICAO	FBO	DATE	ETA	ICAO	FBO	AMBULANCE	POC	TELEPHONE
LEG 1											
LEG 2											
LEG 3											
LEG 4											
LEG 5											
LEG 6											
LEG 7											

SMTAA						VETAIR			VA
DISPATCH A0430 X 5393.25	SMALL TURBINE FLIGHT HOURS T2007 X 2560.50 Q15 min	MEDIUM TURBINE FLIGHT HOURS T2007 X 2900.50 Q15 min	LARGE TURBINE FLIGHT HOURS T2007 X 3060.50 Q15 min	LIVE MILES A0435 X 15.75	SUB TOTAL DUE SMTAA	GND AMB A0426 A0390 X 1464.38	OPS CENTER T2041 X 156.50 Q15 min	SUB TOTAL DUE VETAIR	TOTAL BILLED TO VA
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

VETAir Certifying Official: I the undersigned SUBMIT THIS QUOTE

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION E

VETAir Certifying Official: I the undersigned APPROVE THIS QUOTE

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION F

VA Certifying Official: I the undersigned APPROVE THIS MISSION AT THE ABOVE QUOTED RATE

NAME _____ TITLE _____ SIGN _____ DATE _____

VAMC/VISN NAME _____ EMAIL _____ TELEPHONE _____

SECTION G

VETAir Certifying Official: I the undersigned ASSIGN CONTROL OF THIS MISSION TO OPERATIONS

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION H

NURSE		PHONE	
BED COMING FROM		BED GOING TO	
DX/HPI:			
PERTINENT PAST MED HX:			
0XYGEN:		SPECIAL EQUIPMENT:	
NC / MASK @	lpm	BPUMP / LVAD / OTHER	
CPAP / BIPAP / VAPOTHERM / VENT		NG TUBE / CHEST TUBE	
SETTINGS		SETTINGS	
OTHER		OTHER	

MEDICATIONS:			
IV / IM / PO			
IV / IM / PO			
IV / IM / PO			
IV / IM / PO			
IV / IM / PO			
IV / IM / PO			
IV / IM / PO			
ALLERGIES			
VASCULAR ACCESS:			
SITE	GAUGE	UIDS/MONITOR	
VEIN /ART/OTH			
VEIN /ART/OTH			
VEIN /ART/OTH			

LATEST VITAL SIGNS				
HR	PULSE	BP	O2SAT	
LATEST LABORATORY VALUES				
PT	PTT	INR	TROPONIN	
NA+	K+	GLUCOSE		
BUN	CREAT	PH	BASE	
LATEST EKG				
RATE	RHYTHM	ISCHEMIC CHANGES	BLOCK	
LATEST IMAGING				
XRAY / CT / MRI / ANGIO / VENO / USOUND / SCOPE				

VETAir Certifying Official: I the undersigned VERIFY THE ABOVE INFORMATION IS ACCURATE

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION I

SMTAA Certifying Official: I the undersigned ACCEPT THIS MISSION

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION J

VETAir Certifying Official: I the undersigned VERIFY THIS MISSION IS APPROVED, ACCEPTED, AND CLEARED TO EXECUTE

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION K (COMM CENTER USE ONLY)

	ATD	ICAO	ATA	ICAO	ALIBI	AMB AT ARPT	DELAY	ALIBI	SMTAA CREW		TAIL#:
LEG 1									POSITION	NAME	TELEPHONE
LEG 2									PILOT		
LEG 3									PILOT		
LEG 4									NURSE/MEDIC		
LEG 5									MEDIC/NURSE		
LEG 6											
LEG 7											

VETAir Certifying Official: I the undersigned VERIFY THIS MISSION WAS COMPLETED

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION L

VETAir Certifying Official: I the undersigned VERIFY THIS MISSION WAS BILLED.

NAME _____ TITLE _____ SIGN _____ DATE _____

SECTION M

VETAir Certifying Official: I the undersigned as VERIFY ALL PAYMENTS ARE MADE AND REMITTANCES SENT.

NAME _____ TITLE _____ SIGN _____ DATE _____