MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

Air Ambulance Questionnaire
(Patient/Participant)

Participant: _____ **MPI ID:** _____ **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

_____

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