MEDICAID & MIP OFF-ISLAND REFERRALS

The Medicaid and MIP programs cover eligible recipients for necessary off-island medical services that are not available on island.

1. **OFF ISLAND REFERRAL PACKET:**
    - Off-Island Referral Form: To be completed by the referring physician and submitted with:
        - Supporting medical records such as laboratory/pathology results, X-ray/CAT scan/MRI reports, consultation reports, EKG report, etc.
        - If a Nurse Practitioner signs referral, a physician *MUST* co-sign referral.

    - MEDIF FORM: To be completed by the attending/referring physician within 10 days of departure and signed by the physician and patient/authorized representative
        - If oxygen is needed, **OXYGEN REQUEST FORM** (Guam to Honolulu & Guam to Manila) and **PHYSICIAN'S STATEMENT FOR POC** (Honolulu to U.S) must be attached.

    - Other Health Insurance Documents: If the patient has a primary insurance (private insurance or Medicare).
        - Appointment Card / Statement of Coverage
        - Denial of Airfare with explanation (if not covered by primary insurance)

2. **REVIEW OF REFERRAL REQUEST:**
   The BHCFA Office will review the off-island referral for approval or denial:
    - Approved: Medical records will be sent to an off-island provider for review and acceptance. As soon as the appointment is made, the client will be informed accordingly.
        - Arrangements will be made by the BHCFA Off Island Coordinator

    - Other Insurance: The primary insurance carrier will make the initial arrangements with the provider for the appointment.

3. **LODGING AND GROUND TRANSPORTATION ARRANGEMENTS**
   Lodging, Food, and Ground Transportation are the patient's responsibility.

    - Guam Medical Referral Office (GMRO): **473-1153/473-1154/473-1155**
    - The Medical City Referral Office: **645-5645**

****Off-Island Medical Providers:***

- Children's Hospital Los Angeles – Los Angeles, California
- Rady's Children's Hospital – San Diego, California
- Good Samaritan Hospital – Los Angeles, California
- Sharp Memorial Hospital – San Diego, California
- The Medical City – Manila, Philippines

BHCFA

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), BHCFA may not use or disclose your health information. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

I, _____ hereby authorize the following person (s) to disclose my health information and receive these disclosures of my health information:

1. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

2. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

3. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

4. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

5. **NAME & RELATIONSHIP TO PATIENT: _____**

   Telephone Number: _____

By signing below, I hereby acknowledge that I have read and understand the aforementioned process and I agree that the health information submitted herewith will be used and disclosed for the following reasons:

- Treatment purposes.
- For payment or redirect a third party liability payment for treatment.
- For healthcare operations.

_____ _____

Printed Name and Signature of Patient or Authorized Representative Date

_____

If signed by authorized representative, indicate relationship to patient

MEDICAID
OFF-ISLAND PROGRAM BENEFIT LIMITATIONS

Please **place initials** to indicate that you have read and understood the following:

_____ I understand that off-island medical treatment **requires Prior Authorization and for services not available on island only.**

_____ I understand that **cardiac artificial valves/stents, pacemakers, intraocular lens (IOL) are covered services.**

The following services are *not* covered – transplants and transplant related services (except for children 20y/o and below), palliative and/or experimental treatments, AICD, orthopedic appliances (covered under ABP).

_____ I understand that in the event of death, **cargo transportation service, casket, and mortuary/funeral service are not covered.**

_____ I understand that roundtrip air travel is provided to an eligible patient. **Patient must return to Guam after clearance from the specialist and/or hospital.**
If the patient is a minor, one (1) parent and/or one (1) medical escort when medically necessary.
If the patient is ABP, one (1) companion for specific procedures, one (1) medical escort for specific procedures when medically necessary, and additional escort for specific procedures when medically necessary and unable to self-care.

_____ If I have a primary insurance, I understand that I am responsible in **obtaining the necessary documents from my primary insurance, regarding coverage, approval/denial of the off-island medical referral to include appointments with the accepting off-island provider.**

_____ I understand that I must be **FINANCIALLY READY for the cost of meals, ground transportation, lodging, outpatient medications and any exclusion of medical services and/or co-payment and deductibles.** (Please note: If applicable, meals, lodging, and outpatient medications may be reimbursed upon submission of original invoice/receipts. Reimbursement shall not exceed $25 per day for meals and $50 per day for lodging. Reimbursements do not apply for days that the patient is admitted in the hospital.)

_____ I understand that I am responsible for **expenses incurred with non-participating medical providers.**

_____ If approved, I shall **ensure to inform my eligibility specialist/caseworker that I will be going off-island for medical treatment** and that my **eligibility under the program is current and valid for three months.**

By signing below, I hereby acknowledge that I have read and fully understand the aforementioned program's limitations and my responsibilities and obligations.

_____ _____
Printed Name and Signature of Patient/Authorized Representative Date

_____
Relationship to Authorized Representative

Department of Public Health and Social Services
Division of Public Welfare
Bureau of Health Care Financing

OFF-ISLAND CARE REFERRAL FORM

Patient's Full Name	DOB	Case No.	Hospital No.

Current Address	Telephone No.	Third Party Coverage ☐YES ☐NO
		☐Medicare ☐SelectCare ☐Pacificare
		☐Staywell ☐Multicover ☐Other_____

Detailed Description Of Patient's Health Problems:

Purpose For Sending Patient Off-Island:

Accepting Facility:

Contact was made on:_____

Accepting Physician:

Contact was made on:_____

Date of Departure: Appointment Date:

Approximate Date of Return:

Patient's Certification: I authorize any holder of medical or other information about me concerning my illness or treatment to be released to the Department of Public Health and Social Services or its authorized representatives.

_____ _____
Signature (Patient or Authorized Representative) Date

Attending Physician Signature:

Date:

Action	Consultant Physicians Signature:
☐ Approved ☐ Disapproved Reason:_____ _____ _____	Date:

NOTE: Please attach necessary Medical Summary and all pertinent findings for medical review.

UNITED

MEDICAL INFORMATION SHEET - (MEDIF)

(for official use only)

We understand that your medical information is personal, and we intend to protect the confidentiality of that information. In order to assess your fitness for carriage, however, we must request and obtain from you the information below. The following categories describe different ways that we may use and disclose your medical information. While, not every use or disclosure is listed, all of the ways we will use or disclose information without your authorization will generally fall into one of these categories: (1) to determine your fitness for carriage (2) as required by law (3) avert serious threat to health/safety (4) determine public risk (5) respond to ligation involving transport (6) respond to law enforcement.

This form must be returned to:

(Carrier's Designated Office)

This form is intended to provide CONFIDENTIAL information to assess the fitness of the passenger to travel. If the passenger can be transported, this information will facilitate the issuance of the necessary directives. The ATTENDING PHYSICIAN of the incapacitated passenger is requested to ANSWER ALL THE QUESTIONS: Any blanks will cause a DELAY IN PROCESSING.

TO BE COMPLETED BY PHYSICIAN - IN BLOCK LETTERS

Medical Information Sheet (MEDIF) must be received 48 hours, up to 10 days PRIOR to departure date. MEDIF valid for 10 days unless oxygen is ordered. Oxygen orders expire within 3 days.

MEDA 01 **PATIENT'S NAME** / **(Area Code) Tel. No.** — Date of Travel:

MEDA 02 **ATTENDING PHYSICIAN** - Name & Address — **Sex: M F** — Date of Birth: Month / Day / Year

(Area Code) Tel. No. — Business: — Home: — Mobile:

MEDA 03 **MEDICAL DATA:** DIAGNOSIS in detail with date — Is the patient traveling from a hospital? NO ☐ YES ☐

MEDA 04 List the reasons for medically-related travel with DATE: — PROGNOSIS for flight(s): — SaO2 % (room air) — WEIGHT:

List other medically DIAGNOSED DISEASES:

List recent / relevant surgery or invasive procedures with DATE:

MEDA 05 **IS PATIENT FREE FROM**

- Contagious **AND** communicable disease? NO ☐ YES ☐

If No, has appropriate precautions been provided? NO ☐ YES ☐ Specify:

MEDA 06 - Would the physical and/or mental condition of the patient cause distress or discomfort to other passengers? NO ☐ YES ☐ Specify:

MEDA 07 - Can patient use normal aircraft seat with seatback place in the **UPRIGHT** position when so required? NO ☐ YES ☐

MEDA 08 - Can patient take care of his own needs on board **UNASSISTED** (including meals, visit to toilet, etc.)? NO ☐ YES ☐

MEDA 09 - If **ESCORTED** by whom? (Check **all** that apply) **Escort Name**:_____ **License No.** _____ **Doctor** ☐ **Nurse** ☐ **RRT** ☐ **Family** ☐ **PALS** ☐ **NALS** ☐ **ACLS** ☐

-Will escort be able to meet the care needs of the passenger? (including feeding, toileting, transfers, etc.) **NO** ☐ **YES** ☐

MEDA 10 - Does patient need **OXYGEN** equipment in flight? NO ☐ YES ☐ If Yes: Liters per minute / Liters per hour

- Does patient need **OXYGEN** equipment on **ground**? YES ☐ NO ☐ **If Yes: NAME** and **CONTACT NUMBER** of Provider (**Aviation regulations prohibit use of airline provided oxygen outside of aircraft cabin**).

MEDA 11 / **MEDA 12** - Does patient need any MEDICATION* other than self-administered, or the use of special apparatus? (check all that apply)

(a) during layover: NO ☐ YES ☐ — ☐ **ITS** ☐ **Ventilator** ☐ **IV Pump** ☐ **Suction**

(b) on board of the AIRCRAFT: NO ☐ YES ☐ — ☐ **W/C** ☐ **Stretcher** ☐ **Defibrillator** ☐ **Monitor**

MEDA 13 / **MEDA 14** - **HOSPITALIZATION arrangements confirmed:**

(a) during layover : NO ☐ YES ☐ — Receiving Hospital:

(b) upon arrival at DESTINATION: NO ☐ YES ☐ — Receiving Doctor & Contact Phone No.:

MEDA 15 Additional remarks or information in the interest of the patient's flight transport:

NOTE(*): Cabin attendants are NOT authorized to give special assistance (e.g. lifting) to medical passengers to the detriment of service to other passengers and are NOT PERMITTED to administer any medication.

IMPORTANT: FEES, IF ANY, FOR CARRIER-PROVIDED SPECIAL EQUIPMENT ARE TO BE PAID BY THE PASSENGER CONCERNED.

Place: — Date: — Attending Physician's Signature: — Physician's Name (Print):

PASSENGER'S DECLARATION

"I HEREBY AUTHORIZE" _____

(Print name of attending physician)

to provide the airlines with the information required by those airlines' medical department for the purpose of determining my fitness for carriage by air and in consideration thereof I hereby relieve that physician of his/her professional duty of confidentiality in respect of such information, and agree to meet such physician's fees in connection therewith.

I take note that, if acceptable for carriage, my journey will be subject to the general conditions of carriage and tariffs of the carrier concerned and that the carrier does not assume any special liability exceeding those conditions or tariffs.

I agree to reimburse the carrier upon demand for any special expenditures or costs in connection with my carriage.

Revised March 2017

Passenger's Signature and Date

Copies: Originator / Cockpit / FSC/FFA / GATE Flt File / Customer