Dear

I am submitting this official complaint to you as my health insurance carrier because you have not reimbursed my medically necessary emergency air medical services adequately. Unless you increase your reimbursement to my air ambulance provider, you will be improperly leaving me with a bill that is far higher than I can expect to pay on my own.

My transport was due to an unforeseen medical emergency. In fact, the transport was only completed because of the seriousness of my health condition, and these critical services were determined to be medically necessary by my treating health care provider or the first responder. The initial bill was $ and to date you have only reimbursed a portion of my claim, which leaves me with a large outstanding balance if you refuse to reconsider the sufficiency of your reimbursement. I hope you can understand that your failure to adequately reimburse my provider for this recent critical care transport was an unfair surprise to me.

Your reimbursement to my air medical provider to date is far below usual and customary reimbursement for these medically necessary services. As a beneficiary of your health plan, my premiums and any deductibles and copayments have been faithfully paid in accordance with my plan requirements, with the expectation that you would be there when I need you most. Even though the insurance premiums you are paid continue to rise, it would appear that your coverage for these critical emergency services in my time of need seems to have proportionately shrunk, or that my plan policy limits are being improperly reduced or limited for these services.

I'm asking that you increase the amount you reimburse my air ambulance provider for these services. I'm ready to put this matter behind me to move on with my recovery and my life with peace of mind that this type of service will continue to be available to others in my community that might find themselves in need like I did.

Sincerely,

_____ _____

(Signature) (Date)

CC: Air Methods Corporation, Customer Care Department, P.O. Box 713362, Cincinnati, Ohio 45271

Reference #:

Patient Name:

Date of Birth: Address:

I authorize Air Methods Corporation and any subsidiary or affiliate of Air Methods Corporation, as well as any representative of such entity (collectively, "Air Methods"), to use and disclose my health information as described in this form.

1. **Specific description of the health information:** Air Methods may use and disclose my first and last name and the following information relating to the services provided to me: the date and location of the services provided to me; demographic information; clinical information such as my diagnosis or condition leading to services provided by Air Methods; billing and account related information, including information regarding resolution of my account; and any information I provided to Air Methods regarding my air medical transport or the reimbursement paid by my insurer—whether in the form of a letter, phone call or otherwise.
2. **Persons/classes of persons/organizations authorized to receive the health information:** Air Methods may use and disclose the information specified in Section 1 for the purposes described in this form. Air Methods may include this information in its own or third party printed or electronic publications or presentations to or correspondence with government representatives or public officials. Any person or entity who receives these items or accesses such publications or correspondence may also obtain this information about me.
3. **Purpose of the use or disclosure:** My information described in Section 1 may be used and disclosed for publication in various media, including correspondence with public officials or government representatives, newspaper or magazine articles, television or radio broadcasts, or other similar media.
4. **Remuneration:** Air Methods will not receive payment from a third party for obtaining this authorization or engaging in the marketing communications described above.
5. **Right to Revoke:** I understand that I have the right to revoke this authorization in writing at any time subject to the exceptions stated below. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to: HIPAA Privacy Officer, Air Methods Corporation, 5500 S. Quebec St. Ste. 300 Greenwood Village, CO 80111.
6. **Exceptions To Right of Revocation:** I understand that my written revocation will not affect any uses or disclosures that Air Methods may have made before my revocation was received. For example, any printed materials of Air Methods or of a third party that contain my information may continue to circulate.
7. **Expiration Date/Event:** I understand that this authorization will expire one (1) year from the date that I sign it, except that Air Methods may continue to use and disclose any of my information that is contained in materials created by Air Methods as a result of this authorization for the purposes described above for as long as these items exist.
8. **Prohibitions on Conditions:** Air Methods will not condition treatment, payment, enrollment in a health plan or eligibility for benefits on my signing this form.
9. **Miscellaneous:** I understand that I have no obligation to sign this authorization. Any of my information released pursuant to this authorization may be redisclosed and may be no longer protected by federal privacy regulations if the recipient is not required to comply with federal privacy regulations. I will receive a copy of this form once signed.

Signed this _____ day of _____, 20_____.

Printed name: _____

Signature: _____

<u>If applicable (if signed by a personal representative, parent or legal guardian instead of the patient):</u>

Printed name of patient's representative, parent or legal guardian: _____

Basis of representative's authority to act for patient: _____