BestCare Ambulance Services, Inc. P.O. Box 1057 Alton, NH 03809-1057 1-800-559-5880 Transfers 1-800-439-9293 Business

Procedure: Paperwork: Charge Sheet

Effective Date: Tuesday, March 20, 2001

Reviewed:

Revised:

Accurate Billing is absolutely critical for your paycheck. BestCare uses a charge sheet to assure that patients are correctly charged for all of the services provided.

The form is designed to be used with a highlighter, contained in each BestCare clipboard, but can be done by circling items with a pen. The highlighter is the preferred method.

BestCare Ambulance Services, Inc P.O. Box 1057 Altan, NH 03809-1057 1-800-559-5880								
:RN:	Name				/ 2			
Transport From	: Transport 1	'o:						
Huggins L.R.G.H. Speare BCNH FRH	BI/BW/MG B.C.N.H. CMC Concord		sis L L.R.G.H. Inview Maine Med South M.V.N.H.	Portsmouth W Residence Speare Sunbridge	DH			
Other	Othe		Round Tri					
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1			2					
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L.H.C. wi	pos. revasculariz	ation.	Constant Si Protect pt fr	illed Nursing super	vision			
L.H.C. w Svcs not	pos. revasculariz avail at referering Oxyge	n Central Line	Constant Sł Protect pt fr 2	illed Nursing super	vision			
LH.C. w Svcs not	pos. revasculariz avail at referering Oxyge	n Central Line r Chest Decom	2 Constant SX Protect pt fr Services ETT IO Surgical Airway	illed Nursing super	vision			
LH.C. we Svos not 1 Care Level Basic Intermediate Paramedic DSW DSW 1/2 NS	Coxyge Coxyge Monito	n Central Line r Chest Decom Defib/Pacing Medicat 2 3 4	2 Constant SX Protect pt fr Services ETT IO Surgical Airway	illed Nursing super	vision			
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LH.C. wi Svcs not Svcs not 1 Care Level Basic Intermediate Paramedic DSW DSW 1/2 NS Dopamine	Lidocaine Nitroglycerin	n Central Line r Chest Decom Defib/Pacing Medicat 2 3 4 2 3 4 2 3 4	2 Constant SX Protect pt fr Services ETT IO Surgical Airway	Siled Nursing super om injury during trij	vision p			

PCRN

The first request for information is the PCRN which is a BestCare accepted abbreviation meaning Patient Care Record Number

PCRN_____

The PCRN can be found in the top center of the front Page on the New Hampshire Run Sheet

BIRCHWOOD BUSI	VESS PRODUCTS PLEASE PPT O HEMLY	
	the of the same i decin record	
SERVICE BOST	LUCE ICITIE FI DATE STETOI	CAL No.
DISPATCHED TO	IRGH Jaconia	Skile
PATIENT NAME	artman Eric	Pertment Mindflung Hic
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DO.8. 6 113 93	AGE 8 0 + 25.0 1 × 3-4	EMS RESPONSE TIMES
NOTIFY:		Tores Services
CHIEF COMPLAINT	CP LHC	LEAVE SCORE AT INCOMOLE IN SCORES
Hx PRESENT ILLNESS/ MECHANISM OF INJURY		
TIME (24 Hour) LO.C.	PULSE BP RESPRATIONS	LUNG SOUNDS PUPILS SKIN TEMPERATURE
AV PU	Regular beg Serveg Resear / Berned Accord Serveg Resear / Berned Bellevel Serveg Resear Accord Berned Accord	
PU AV	Charge Wate Charge Charge Charge Charge	Status Constraint Distant Constraint
AV PU	Strong Titula Calcored Study	nal Wheeves Discorposite
NARRATIVE should inci		
Time	Trooment Resulted	Disensions NH ALSP
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	JUGE >15:59 23 JUL 01 LEAD II X0.8 Amount of the second secon	Standard NH A.50" HF = 95

This number must be accurately copied. It must be clearly written as this is a complete link to all of the data for this patient.

Enter the Patient Name and Date of Service in the spaces Provided.

PCRN 934267 Name Cartman Eric DOS 812312001

Transport From and to:

There are currently five choices on this form for the "from" location from which a patient can be transported, reflecting the facilities we serve most frequently. Please highlight the facility is being transported from.

In the event that the patient is being transported from a facility that is not listed. Then it is should be written in after Other in this section. Common abbreviations are acceptable, however is there is uncertainty, or it is a facility that we have never transported from, please write out the whole name.

In the example below the patient is being transported from Speare Memorial Hospital in Plymouth, NH.

Transport From:	Transport 1	ſo:				
Huggins L.R.G.H. Speare BCNH FRH	BI/BW/MG B.C.N.H. CMC Concord	DHMC Elliot Franklin Frisbie	Genesis F Genesis L Goldenview HealthSouth	Huggins L.R.G.H. Maine Med M.V.N.H. Round Trip	Portsmouth Residence Speare Sunbridge	WDH
Other	Othe	r				

There are currently twenty one choices on this form for the "to" location from which a patient can be transported, reflecting the facilities we serve most frequently. Please highlight the facility is being transported from.

In the event that the patient is being transported to a facility that is not listed. Then it is should be written in after "Other" in this section. Common abbreviations are acceptable, however if there is uncertainty, or if it is a facility that we have never transported from, please write out the whole name.

In the example above the patient is being transported to Catholic Medical Center in Manchester, NH

In some instances a patient will go for a round trip. Such as for a specific procedure. Like a MRI or ERCP. Highlight round trip to save writing a completely new packet.

Diagnosis and reason for transport.

The most common diagnosis for transporting patients are written on the charge sheet so that they may be easily highlighted.

There are many diagnosis or conditions which may need to be written into the space provided for diagnosis.

In the example below the chief complaint or diagnosis which makes the ambulance service necessary is USA, or Unstable Angina.

				Di	agnosis		
USA A-fib	AMI Cardiol	Syncope Myopathy	CVA V-tach	CHF	COPD	Inter-cranial bleed	Dementia
1			in a		2	1.1.1.1.1.1.1	
– L.H		Ju Pacemaker s. revasculariz iil at referering	Reha		nbulance ACLS	Transportation Immob for FX. Constant Skilled Num Protect pt from injury	
_ 010	S not are		J (0.011)			_	

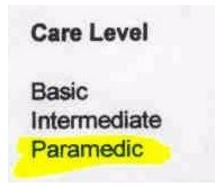
The most common reasons justifying why a patient must be transported by an ambulance, as opposed to a wheelchair van or taxi, are written on the charge sheet so that they may be easily highlighted.

There are many justifications or conditions which may need to be written into the space provided for this.

In the example above the patient must be transported because he needs a Cardiac Catheterization, and these services are not available at the referring facility. Bear in mind that this is not a complete list and that accurate completion of the Narrative fill in form is integral to the successful billing which pays our salaries.

Care Level

The Care level is the BestCare staffing level required to treat a patient. Basic, Intermediate, Paramedic.

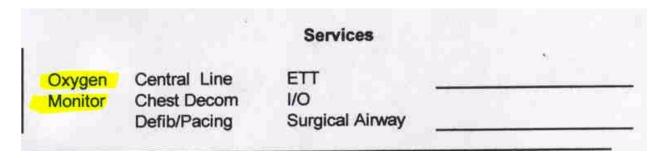


In certain circumstances a paramedic or intermediate may be required even if no advanced skills are performed. An example would be a patient with a hep-lock who may or may not need pain control during a transport.

In these instances this need for higher level care should also be indicated on the New Hampshire transfer sheet as well.

Services

Services describe procedures for the most part. Please highlight any procedures given to the patient during transport. If they are not listed, please write them in.



Medications

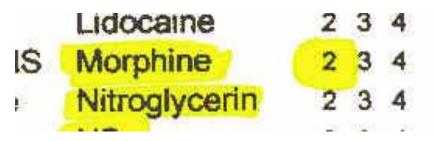
					Medications				
D5W	Lidocaine	2	3	4					
D5w 1/2 NS	Morphine	2	3	4		2	3	4	
Dopamine	Nitroglycerin	2	3	4					
Heparin	NS	2	3	4		2	3	4	
Integrelin	Valium	2	3	4					
LR	Versed	2	3	4		2	3	4	

The most common Medications are written down and can be easily highlighted.

There are blank spaces provided to write in drugs not listed.

Drugs such as Morphine which can get multiple administrations have numbers to the right of them which should be highlighted to reflect the number of administrations.

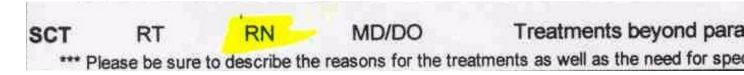
In the example below the patient was given two separate administrations of morphine.



SCT

Specialty Care Transport are ones in which additional staff from facilities must accompany a BestCare crew to meet the needs of the patient.

In the below example a nurse form the hospital accompanied the crew. Presumably for the administration of Integrelin ® which is not on the Paramedic drug list at the time of this writing.



Again the most common are present to be highlighted.

It is assumed that the reason for the need of these additional staffing will be well documented on the Narrative fill in form and an additional explanation will be written on the reverse side of this form.

Please check the self explanatory box to let Carol know there is an explanation or additional treatments listed on the backside of the form.



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