

**UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

PHI HEALTH, LLC

Plaintiff,

v.

**HEALTH CARE SERVICES CORP., A
MUTUAL LEGAL RESERVE COMPANY
D/B/A BLUE CROSS BLUE SHIELD,**

Defendant.

Case No. 1:26-cv-02954

Hon. Matthew F. Kennelly

FIRST AMENDED COMPLAINT AND MOTION TO CONFIRM AWARD

Plaintiff PHI Health, LLC (“Plaintiff” or “PHI”) files this Complaint and Motion to Confirm Award against Health Care Services Corporation, a Mutual Legal Reserve Company d/b/a Blue Cross Blue Shield (“Defendant” or “HCSC”), individually and as the agent for the benefits plans it administers and/or insures (the “Plans”), for its failure to pay overdue awards issued pursuant to the No Surprises Act (“NSA”) governing medical billing.

I. INTRODUCTION

1. HCSC is violating the NSA and engaging in similar unfair and deceptive trade practices. Rather than Independent Dispute Resolution (“IDR”) proceedings being a quick, efficient way to resolve payment disputes between out-of-network providers of emergency services and health plans, HCSC, on behalf of itself and as authorized agent for health benefits plans, uses the NSA to further its crusade to deny, delay and underpay out-of-network providers of emergency medical services. After providers receive low initial payments, providers must jump

through the many hoops in the NSA to receive an award of fair compensation. And, once they receive an IDR award, HCSC simply does not pay it or delays payment far beyond the NSA's statutorily-mandated 30-day payment deadline and does not include interest on the late payment. In addition, HCSC encourages and/or directs its clients—Plans and their sponsors—not to comply with the NSA's mandatory payment obligations. This “low pay, late pay or no pay” scheme often results in providers not receiving fair compensation until many months and sometimes years after the emergency transport occurred, if they ever receive it at all.

2. This case seeks enforcement—not review—of binding federal payment determinations. PHI does not ask this Court to revisit the merits of any IDR award. PHI seeks only to compel Defendant to comply with their statutory obligation to pay those awards.

3. The NSA mandates that IDR determinations “shall be binding upon the parties” and that payment “shall be made directly to the nonparticipating provider not later than 30 days” after the determination. These provisions create a mandatory, money-mandating obligation.

4. Defendant has refused to comply with these mandatory obligations. More than 30 days—and in many cases many months—have passed since issuance of the IDR awards, yet Defendant has not paid.

5. Without judicial enforcement, these “binding” awards would be rendered meaningless, and Defendant could ignore federal law with impunity.

6. This scheme also falls squarely within the type of unfair and deceptive trade practice prohibited by the State of Illinois. HCSC, on behalf of itself and the Plans, has late-paid or not paid air ambulance operators *many millions* of dollars in IDR Awards, including \$249,428.76 owed to PHI. HCSC is ignoring federal law and colluding to violate Illinois state law; it must be held accountable.

7. PHI therefore applies, pursuant to the NSA, the Federal Arbitration Act (“FAA”), the Illinois Consumer Fraud and Deceptive Business Practices Act (“ICFA”), the Illinois Uniform Arbitration Act (“IUAA”), and the Employee Retirement Income Security Act (“ERISA”), and/or as a matter of declaratory and/or equitable relief for a judgment confirming the IDR awards and awarding Plaintiff for \$ 249,428.76 (the “IDR Award Balances Owed”), in addition to attorneys’ fees, costs, and interest. The persistent pattern of delay and denial additionally warrants the recovery of punitive damages from HCSC.

II. PARTIES

Plaintiff

8. Plaintiff PHI Health, LLC is a limited liability company organized under the laws of the State of Louisiana and headquartered in Tempe, Arizona.

9. HCSC is a mutual legal reserve company (i.e., corporation) organized under the laws of the State of Illinois and is headquartered in Chicago, Illinois. HCSC operates the Blue Cross Blue Shield entities in Illinois, Oklahoma, New Mexico, Texas, and Montana. For individuals who are insured by other Blue Cross Blue Shield entities but are treated in these states, HCSC operates as the “home plan” and adjudicates claims on behalf of the Plans and Blue Cross Blue Shield entities. HCSC (a) provides individual health insurance to individuals and their families (e.g., ACA Marketplace plans); (b) fully insures group health and welfare benefits plans; or (c) acts as a third-party administrator (“TPA”) for self-insured health and welfare benefits plans. The plans referenced in the latter two categories are governed by the Employee Retirement and Income Security Act (“ERISA”).

III. JURISDICTION AND VENUE

10. This Court has federal question jurisdiction pursuant to the NSA, which includes a right to payment of IDR awards within thirty days of issuance. *See, e.g.*, 29 U.S.C. § 1185e(c)(5)(A); 42 U.S.C. § 300gg-111(c)(5)(A); 28 U.S.C. § 1331.

7. The Court has personal jurisdiction over HCSC because it is an Illinois company that is headquartered in Chicago, Illinois.

42. Venue is proper under 28 U.S.C. § 1391(b)(2) because PHI's claims arise from HCSC's non-payment of IDR awards, which takes place at its headquarters in this District.

IV. FACTUAL BACKGROUND

A. The Importance of PHI's Service.

11. The air ambulance industry plays an integral role in the American healthcare system, and PHI provides an essential service for many Americans. Air ambulances serve as the only lifeline connecting critically ill and injured patients to healthcare, particularly in rural communities. They transport trauma, stroke, heart attack, and burn patients and other emergent cases requiring critical care. Today, at least one quarter of Americans (85 million) cannot access a Level 1 or 2 trauma center within an hour of when emergency care is needed.¹

12. The delivery of on-demand, life-saving air ambulance services requires substantial investments in specialized aircraft, air bases, technology, personnel, and regulatory compliance systems. As recognized by a bi-partisan group of Senators and Representatives, "When seconds matter, air ambulances have proven to be the best way to care for patients in need."²

¹ <https://www.cornellhealthcarereview.org/post/critical-lifelines-air-ambulances-in-rural-america>

² Estes, Delbene, Bennet, Blackburn Introduce Legislation to Support Ambulances in Rural America, July 30, 2025, <https://estes.house.gov/news/documentsingle.aspx?DocumentID=7091>.

13. HCSC, on behalf of itself and as a director orchestrating action in concert with the Plans and their sponsors, made calculated and deliberate decisions to ignore both their coverage obligations and the IDR process, while at the same time reaping the benefits of the services, on behalf of themselves and the Companies and Plans. This conduct is antithetical to the NSA or to the rational and proper functioning of the U.S. healthcare system.

B. Background on the No Surprises Act.

14. The NSA became effective January 1, 2022. It is implemented and enforced by the combined efforts of the U.S. Departments of Labor, Health and Human Services, and the Treasury (the “Departments”), which together created a mandatory federal dispute resolution process to determine pricing for all out-of-network emergency air ambulance transports of patients who are covered by commercial health plans.

15. The NSA creates a federal obligation for group health plans and health insurers to pay out-of-network providers of air ambulance services. In total, the group health plans and health insurer must pay the applicable “out-of-network rate” due for the service, less any cost-sharing amount owed by the patient.

16. In enacting the NSA, Congress fundamentally altered the legal rights of out-of-network emergency providers. The statute expressly prohibits providers from balance billing patients for emergency services and extinguishes providers’ ability to pursue payment from patients or through state-law or common-law causes of action. In place of those rights, Congress created a comprehensive federal payment scheme under which providers must seek compensation exclusively through the NSA’s negotiation and IDR processes, culminating in a binding payment determination.

17. Pursuant to the statute, a group health plan or insurer has 30 days from which the bill for a covered service is transmitted by the provider to pay or deny the claim. 29 U.S.C. § 1185e (b)(1)(C); 29 U.S.C. § 1185f(a)(3)(A); 42 U.S.C. § 300gg-111(b)(1)(C); 42 U.S.C. § 300gg-112(a)(3). If initial payment is too low, the provider may initiate an “open negotiation period” to attempt to negotiate a higher amount. 29 U.S.C. § 1185e (c)(1)(A); 29 U.S.C. § 1185f (b)(1)(A); 42 U.S.C. § 300gg-111(c)(1)(A); 42 U.S.C. § 300gg-112(b)(1). If the negotiations fail, the provider may initiate the IDR process. 29 U.S.C. § 1185e (c)(1)(B); 29 U.S.C. § 1185f (b)(1)(B); 42 U.S.C. § 300gg-111(c)(1)(B); 42 U.S.C. § 300gg-112(b)(2).

18. The IDR process is baseball-style arbitration. It requires each side to submit position statements and proposed offers of payment for the services at issue to a third-party IDR entity. 29 U.S.C. § 1185e (c)(5), 1185f(b)(5); 42 U.S.C. §§ 300gg-111(c)(5), 300gg-112(b)(5)). The IDR entity considers both proposed offers and a number of statutory factors, and, and based on those factors, “select[s] one of the offers submitted . . . to be the amount of payment.” *Id.*

19. The IDR entity’s “determination” is made “binding” by the NSA. The group health plan or insurer must make any additional “payment required” by the determination “directly to the nonparticipating provider **not later than 30 days after** the date on which such determination is made” by the IDR entity. 29 U.S.C. § 1185e(c)(5); 29 U.S.C. § 1185f(b)(5); 42 U.S.C. § 300gg-111(c)(5); 42 U.S.C. § 300gg-112(b)(5) (emphasis added).

20. Once a certified IDR entity issues a determination, the NSA affords the losing party only a narrow and time-limited opportunity to seek vacatur on specified grounds. Absent a timely vacatur challenge, the statute makes the determination final and binding and requires payment within thirty (30) days. The NSA does not authorize any federal agency to compel payment of

individual IDR awards to a prevailing provider, making judicial enforcement the sole mechanism by which prevailing providers may obtain the compensation Congress mandated.

C. PHI Filed Arbitration and Prevailed, Yet HCSC Refuse to Pay.

21. The air ambulance services provided by PHI were emergency air ambulance services furnished by a nonparticipating provider to participants or beneficiaries of group health plans and health insurance coverage are considered “qualified IDR items and services” as defined by 45 C.F.R. § 149.510(xi)(A) and 29 C.F.R. § 2590.717 (as to ERISA plans) and therefore qualify for protection and mandatory payment under the NSA, including 29 U.S.C. §§ 1185e(a)(1) and 1185f(a); 42 U.S.C. § 300gg-112(a).

22. Defendant and the beneficiaries of the Plans received the benefit of PHI’s air ambulance services during times of emergent medical needs. In many situations, lives were saved or more serious conditions avoided (and thus the costs associated therewith).

23. PHI followed industry standard billing process for billing HCSC, in its capacity as insurer and plan administrator, for these transports. In response, HCSC sent PHI “Explanation of Benefits” (“EOB”) forms setting forth initial low underpayments to PHI for the two service codes billed for each transport. Because initial payments were deficient, PHI turned to the dispute resolution plan set forth in the NSA. For the claims at issue, in some instances, HCSC invited PHI to participate in dispute resolution. In others, HCSC violated the NSA and failed to include required disclosures about how to initiate the IDR process. 29 C.F.R. § 2590.716-6(d)(1); 45 C.F.R. § 149.140(d)(1).

24. In response to these deficient payments, PHI timely initiated the open negotiation process. The dates on which open negotiation was initiated for the unpaid awards are listed on Exhibit A. The parties were ultimately unable to agree to fair payment for the transports during the open negotiation periods.

25. When open negotiations failed, pursuant to the NSA, PHI timely initiated IDR proceedings by submitting notices of initiation through the federal IDR portal for each of the transports and service codes at issue. The dates on which IDR proceedings were initiated are listed on Exhibit A. The IDR determinations were in PHI's favor, which resulted in PHI being owed additional payments for the out-of-network transports.

26. HCSC received notice of each IDR proceeding and participated in all of them without objecting to PHI's standing or authority to pursue payment.

27. The determinations were issued via written payment determination notices, which include the "IDR Awards." *See* Exhibits A and B. HCSC has not sought vacatur, modification, or correction of any IDR Awards identified in Exhibits A and B within the three-month period prescribed by law. 9 U.S.C. § 12. Because HCSC failed to invoke the limited vacatur procedures authorized by the NSA and the FAA within the time permitted, the IDR Awards are final and binding. Any objections HCSC has since asserted fall outside the exclusive statutory process for challenging an IDR determination and do not justify non-payment.

28. HCSC frequently does not comply with the 30-day payment requirement. When the claims for services are finally paid, HCSC provides low reimbursement, hoping providers will find the IDR process too burdensome, or providers will fail in one of the numerous steps in the IDR process and/or miss one of the NSA's strict deadlines. This forces providers to go through the costly and burdensome IDR process on every transport.

29. When all of these steps to delay and deny have failed, and PHI finally has binding determination awards from IDR entities in its favor, HCSC simply ignores them.

30. On the occasions when IDR awards are actually paid, HCSC unreasonably delays payment and does not include interest to account for the time value of the money that has been

illegally withheld. For example, HCSC owes PHI \$597,751.53 for IDR awards issued in March 2026 alone. Even after outside counsel becomes involved, HCSC takes months to conduct “investigations” into claims and sometimes misrepresents that outstanding claims are paid when they are not.

31. HCSC knows it is statutorily required to pay IDR awards within 30 days. However, HCSC does not invest in the compliance systems and personnel needed to meet its obligations under federal law, even now, over four (4) years after the adoption of the NSA, and HCSC does nothing to encourage or empower the Plans and companies to pay the awards. HCSC knows it profits from lack of compliance and violation of the mandatory payment obligations of the NSA. HCSC knows the longer it delays payment, the more it earns from the interest and/or investment income.

32. Additionally, HCSC knows it must compete with other companies for the administrative fees those plans generate. By delaying payment or not paying IDR awards, HCSC is able to keep the health plans’ claims costs arbitrarily low, thus incentivizing plans to stay with HCSC and/or using the results to market HCSC services to other health plans.

33. This practice and policy of failure to timely pay IDR awards has become a widespread business practice. This business practice is evidenced by 1) the numerous unpaid and/or late paid IDR awards owed by HCSC to PHI, including the almost \$250,000 due in this case and 2) the fact that other providers of emergency services are being subjected to the same widespread unfair business practices (See *Guardian Flight, LLC v. Aetna Life Insurance Company*, No. 24-00680). Based on the number of similar lawsuits filed throughout the country, many other emergency service providers are subject to the same widespread unfair business practices.

34. On information and belief, from its Illinois headquarters, HCSC regularly reports payment practices, including the timing and non-payment of IDR awards, to the Plans and Companies they administer. The Plans and Companies retain ultimate authority to approve, fund, or withhold payment of amounts determined through the IDR process, including awards that have become final and binding under federal law. By continuing to authorize or tolerate non-payment after receiving notice of binding IDR determinations, the Plans and Companies knowingly ratified and benefitted from the unlawful conduct alleged herein.

35. PHI seeks to enforce the outstanding balances remaining on the IDR Awards. PHI seeks interest on all awards. PHI further seeks post-judgment interest, attorney's fees, costs, punitive damages and equitable relief.

V. CLAIMS

Count 1: Confirmation of IDR Awards Under the NSA (29 U.S.C. § 1185e(c)(6); 29 U.S.C. § 1185f(b)(6)); 26 U.S.C. § 9817; and 42 U.S.C. § 300gg-112)

36. PHI incorporates by reference the allegations of the preceding paragraphs.

37. The NSA creates enforceable rights for providers like PHI. The NSA uses clear, mandatory, rights-creating language, including that a determination of a certified IDR entity “*shall be binding upon the parties involved*” and that payment “*shall be made directly to [PHI] not later than 30 days after* the date on which such determination is made” by the IDR entity. 29 U.S.C. § 1185e(c)(6); 29 U.S.C. § 1185f(b)(6) (emphasis added).³ These provisions impose a specific obligation to pay a sum certain to providers by a date certain. PHI, as a provider, is within the class of entities the NSA is designed to protect.

38. These provisions are phrased in explicit, rights-creating terms and are unmistakably

³ And, as applicable, 26 U.S.C. § 9817 and 42 U.S.C. § 300gg-112.

focused on the class of entities Congress intended to benefit—out-of-network emergency providers that prevail in the IDR process. They therefore satisfy the standard articulated in *Health & Hosp. Corp. of Marion Cnty. v. Talevski*, 599 U.S. 166 (2023) and *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) for the creation of enforceable federal rights.

39. More than 30 days have passed since the IDR Award was issued, and PHI has not received payment. Defendant has not timely filed suit to vacate the IDR Award pursuant to the limited grounds authorized by statute; they simply have not paid the award at all.

40. Under the FAA, any motion to vacate an arbitration award must be served within three months after the award is filed or delivered. 9 U.S.C. § 12. Defendant did not seek vacatur within that period for the IDR Award subject to this case and are therefore barred from collaterally attacking the IDR Award.

41. Because the NSA expressly renders IDR awards “binding” and mandates that payors “shall” pay the determined amounts within 30 days, PHI pursues its right to prompt payment of the IDR Award through this action.

42. The NSA does not merely regulate conduct; it imposes a money-mandating obligation. Congress specified that a prevailing provider is owed a specific amount (as determined by the certified IDR entity), from a specific payor (the plan or insurer that participated in the IDR process), by a date certain (no later than 30 days after the determination). Statutes that impose such mandatory payment obligations have long been understood to create enforceable rights and remedies, particularly where, as here, the obligation is fixed, final, and non-discretionary. *See, e.g., Maine Cmty. Health Options v. United States*, 590 U.S. 296, 324–28 (2020) (“Statutory ‘shall pay’ language often reflects congressional intent to ‘create both a right and a remedy’”).

43. In enacting the NSA, Congress expressly prohibited providers from balance billing

patients and extinguished common-law and state-law avenues for recovery. The IDR process and the mandatory payment obligation that follows a binding determination are the exclusive means by which providers may obtain compensation. It is inconceivable that Congress intended to strip providers of all alternative remedies while simultaneously leaving prevailing providers without any mechanism to enforce binding federal payment determinations.

44. This action does not seek judicial *review* of the merits of any IDR determination. Congress sharply limited judicial review of IDR awards to narrow vacatur grounds under the FAA, 29 U.S.C. § 1185e(c)(5)(E)(i)(II). Judicial *enforcement* of a binding award, however, is categorically different from judicial review and is necessary to give effect to Congress’s command that binding determinations be timely paid. *PHI Health, LLC v. Optimum Choice, Inc. d/b/a United Healthcare*, No. 25-CV-2320-ABA, 2026 WL 850453, at *9 (D. Md. Mar. 27, 2026); *see also Richard Agag, MD v. Cigna Health & Life Ins. Co.*, No. 3:25-CV-00498 (SRU), 2026 WL 1021213, at *13 (D. Conn. Apr. 15, 2026).

45. No federal agency is authorized to enforce payment of individual IDR awards. Although the Departments may impose limited civil monetary penalties for non-compliance, those penalties are payable to the government, are untethered to the amount of any unpaid award, and do not result in payment to the prevailing provider. Absent judicial enforcement, Defendant could ignore binding IDR determinations with impunity, rendering Congress’s carefully constructed dispute-resolution framework meaningless. *PHI Health*, 2026 WL 850453, at *8; *Guardian Flight LLC v. Aetna Life Ins. Co.*, 789 F. Supp. 3d 214, 227–29 (D. Conn. 2025); *Richard Agag, MD*, 2026 WL 1021213, at *13.

46. Absent judicial enforcement, the NSA’s declaration that IDR determinations are “binding” and “shall” be paid would be rendered precatory rather than mandatory, contrary to

Congress's express design.

47. Congress eliminated providers' ability to recover from patients and replaced those rights with a federal payment mechanism. Without judicial enforcement, these statutory rights would be illusory.

48. The amounts owed on unpaid, partially paid, and late-paid awards plus prejudgment and post-judgment interest should be issued as a final judgment.

Count 2: Action for Payment of IDR Award Under FAA
(9 U.S.C. §§ 1, et seq.)⁴

49. PHI incorporates by reference the allegations of the preceding paragraphs.

50. The IDR process constitutes arbitration within the meaning of the FAA.

51. Defendant agreed to binding dispute resolution by, *inter alia*, inviting IDR through EOB communications; participating in IDR proceedings; and submitting offers and arguments.

52. The IDR entities acted as neutral adjudicators.

53. The IDR Award is a valid arbitration award that has not been vacated or set aside by any authority.

54. Confirmation is not "judicial review" but rather entry of the awards previously rendered. The IDR Awards should be confirmed by judgment of this Court pursuant to the FAA, 9 U.S.C. § 9.

55. The foregoing declarations, in whole or in part, would settle this ongoing payment controversy. Without a declaration concerning PHI's rights and interests relating to the services it

⁴ This claim is pleaded in the alternative. Plaintiff seeks enforcement of the IDR Award primarily under the NSA itself, which independently renders IDR determinations binding and mandates payment within thirty (30) days. Plaintiff asserts this FAA claim only to the extent the Court were to conclude that the NSA does not itself authorize judicial enforcement of unpaid IDR determinations.

provides and the enforcement of IDR awards, including payment of the IDR Award Balance Owed, PHI will continue to suffer damages on existing and future claims for services.

Count 3: Action for Payment of IDR Awards Under IUAA
(710 ILCS 5/1, et seq.)

57. PHI incorporates by reference the allegations of the preceding paragraphs.

58. HCSC administered the Plans under which PHI provided covered medical services to beneficiaries.

59. PHI and HCSC participated in the IDR process following completion of the required open negotiation period, which establishes an “agreement to arbitrate.”

60. Each disputed claim identified in Exhibit A was submitted to a certified dispute resolution entity acting as a neutral adjudicator.

61. For each claim listed in Exhibit A, the certified IDR entity issued a written determination selecting PHI’s offer and awarding a specific payment amount. Those awards are at Exhibit B.

62. Those IDR determinations are final and binding under federal law.

63. The IDR proceedings constitute arbitration within the meaning of 710 ILCS 5/1 because the parties submitted payment disputes to neutral decisionmakers for final and binding resolution.

64. HCSC has not moved to vacate, modify, or correct any IDR determination within the time permitted under 710 ILCS 5/12 or 710 ILCS 5/13.

65. More than ninety days have elapsed since issuance of the IDR determinations.

66. No statutory grounds exist to vacate or modify the awards.

67. Despite the binding nature of the determinations identified in Exhibit A, HCSC has failed and refused to remit payment in accordance with multiple IDR Awards across multiple Plans.

68. Pursuant to 710 ILCS 5/11, this Court shall confirm the arbitration awards unless grounds are timely urged for vacatur or modification.

69. PHI is entitled to confirmation of each IDR determination identified in Exhibit A and entry of judgment in the amounts awarded, together with applicable interest.

Count 4: Declaratory and Injunctive Relief
(28 U.S.C. § 2201)

70. PHI incorporates by reference the allegations of the preceding paragraphs.

71. PHI brings this claim pursuant to 28 U.S.C. § 2201 for a declaratory judgment regarding its rights to enforcement of the applicable IDR awards and entitlement to the IDR Award Balances Owed.

72. PHI has an actual, tangible, legal interest in the matter at issue, namely, that it is entitled to the IDR Award Balances Owed.

73. HCSC has an adverse or opposing interest to PHI's legal interest.

74. An actual, concrete, and justiciable controversy exists among the parties as it relates to HCSC's obligation to pay the IDR Award Balances Owed, which is thus suited for declaratory relief pursuant to 28 U.S.C. § 2201.

75. Declaratory judgment is appropriate if a justiciable controversy exists as to the rights and status of the parties and the controversy will be resolved by the declaration.

76. PHI seeks a declaration that the IDR Awards at Exhibits A and B are binding on HCSC (either directly or as agent of the health benefit plans listed on Exhibit A), and any objections lodged by HCSC are overruled. PHI further seeks a declaration that HCSC's conduct

in refusing to pay IDR awards that have not been vacated in the limited manner permitted under the NSA is unlawful.

77. As a result of the foregoing declarations, PHI will be protected from HCSC's continued refusal to pay PHI amounts it is owed for its services.

78. Such declarations are proper and necessary under the existing circumstances in order that the Parties may ascertain their rights and obligations.

79. The foregoing declarations, in whole or in part, would settle this ongoing payment controversy. Without a declaration concerning PHI's rights and interests relating to the services it provides and the enforcement of IDR awards, including payment of the IDR Award Balance Owed, PHI will continue to suffer damages on existing and future claims for services.

Count 5: Claim for Enforcement of NSA Under ERISA and Payment of Plan Benefits
(ERISA 29 U.S.C. §§ 1332(a)(1)(B) and 1332(a)(3))

*(Limited to awards involving ERISA plans:
Accounts 360577, 361538, 413683, 435500, 418520, 436602, 443361)*

80. PHI incorporates by reference the allegations of the preceding paragraphs.

81. On information and belief, PHI account numbers 360577, 361538, 413683, 435500, 418520, 436602, 443361 involve patients transported by PHI ("Patients") who, at the time of the transport, were participants in or beneficiaries of employee welfare benefit plans—specifically group health plans—subject to the ERISA. The benefits plans that apply to these accounts will be called the "ERISA Plans," and "ERISA Plans" shall include their plan sponsors and administrators.

82. Upon information and belief, the names of the ERISA Plans and their sponsors are set forth at Exhibit A.

83. With respect to the air ambulance services provided by PHI on the dates set forth on Exhibit A, PHI has been assigned all of Patients' claims under and with respect to the ERISA

Plans, including Patients' rights under 29 U.S.C. §§ 1332(a)(1) and (a)(3) such as to recover benefits due and to seek equitable relief. *See Exhibit C.*

84. PHI thus has stepped into the shoes of Patients and is now considered a beneficiary of the ERISA Plans pursuant to 29 U.S.C. § 1002(8).

85. Subchapter I of ERISA incorporates requirements of the NSA, including NSA's requirement that a determination of a certified IDR entity "shall be binding upon the parties involved" and that payment "shall be made directly to the nonparticipating provider not later than 30 days after the date on which such determination is made." 29 U.S.C. § 1185e(c)(5)(E)(i)(I); *id.* § 1185f (b)(5)(D), (6); *see also id.* § (a)(3)(B).

86. Upon information and belief, the terms of the ERISA Plans incorporate NSA requirements. Among those requirements is the obligation for IDR written determinations to be fully paid within 30 days.

87. As the assigned beneficiary, PHI is entitled to enforce the requirements of the NSA, as incorporated into ERISA and, in turn, the terms of the ERISA Plans—including the duty to pay written determinations within 30 days.

88. On information and belief, the ERISA Plans—including their guarantee of NSA-complaint coverage for air ambulance services—were provided as consideration for labor services provided by Patients or their immediate family members, who also paid at least a portion of the premiums due for such coverage. The benefits purchased with that consideration were supposed to ensure that Patients' air ambulance providers were fully compensated for their services consistent with the terms of the ERISA Plans and ERISA itself.

89. Patients also have a strong and concrete interest in ensuring that their group health plans comply with the NSA's requirement that they fully and promptly satisfy IDR written determinations.

90. Under 29 U.S.C. § 1132(a)(1), PHI, as assignee-beneficiary, is entitled to sue "to recover benefits due to [it] under the terms of his plan, to enforce [its] rights under the terms of the plan, or to clarify [its] rights to future benefits under the terms of the plan."

91. The benefits due to PHI, as assignee-beneficiary, under the terms of the ERISA Plans include the amounts due pursuant to the written determinations. Upon information and belief, the rights of PHI, as assignee-beneficiary, under the terms of the ERISA Plans include having the ERISA Plans (either directly or acting through their administrators) pay the written determination within 30 days.

92. Under 29 U.S.C. § 1132(a)(3), PHI, as assignee-beneficiary, is entitled also to sue "to enjoin any act or practice which violates any provision of [ERISA subchapter I] or the terms of the plan" or "to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [ERISA subchapter I] or the terms of the plan." The ERISA Plans' refusal (through their agent, HCSC) to pay written determinations within the 30-day deadline is an act or practice which violates ERISA subchapter I and the terms of the ERISA Plans.

93. The ERISA Plans' and HCSC's failure to pay the written determinations within 30 days (and ongoing refusal to do so) violates the Patients' (and therefore PHI's) rights under ERISA (including 29 U.S.C. §§ 1185e & 1185f) and the terms of the ERISA Plans. That failure to pay constituted an abuse of discretion by i) improperly interpreting and applying the ERISA Plans' terms that are not ambiguous; ii) exercising discretion over non-discretionary terms in the ERISA Plans; and iii) denying PHI payment and benefits under the terms of the ERISA Plans.

94. The denial of payment and benefits owed on written determinations were not substantially justified decisions, were arbitrary and capricious, were unsupported by substantial evidence, constituted abuse of any discretion allowed, and were wrongful under all of the circumstances. The payment obligations with respect to a written determination are automatic and unambiguous.

95. Pursuant to 29 U.S.C. § 1132(a)(1) and/or (a)(3), PHI is therefore entitled to relief including: i) damages in the amount of the unpaid amount on the written determination, plus interest; and ii) an affirmative injunction requiring HCSC and the ERISA Plans to comply with their obligations, under the terms of the ERISA Plans and 29 U.S.C. §§ 1185e & 1185f, to pay immediately the amount overdue on the written determination.

96. PHI further seeks equitable relief prospectively enforcing HCSC's and the ERISA Plans' obligation to pay written determinations due to PHI, as assignee-beneficiary, within thirty days, and all other appropriate equitable relief to redress such violations, such as the filing of quarterly reports with the Court certifying compliance for an appropriate period.

97. Pursuant to 29 U.S.C. § 1132(g), PHI further seeks an award of reasonable attorney's fees and costs incurred in bringing this action.

Count 6: Violation of ICFA
(815 ILCS 505/1, et seq.)

98. PHI incorporates by reference the allegations of the preceding paragraphs.

99. HCSC maintains centralized claims administration, payment processing, and corporate policy functions in Illinois. Decisions regarding whether to honor and remit payment on IDR determinations are made, approved, directed, and implemented in Illinois.

100. The acts and practices alleged herein occurred primarily and substantially in Illinois.

101. HCSC markets and sells health benefit plans to Illinois employers and consumers and publicly represents that it complies with federal law, including the NSA, and supports statutory protections designed to shield consumers from surprise medical bills.

102. In public communications directed to consumers and employers, HCSC represents that it implements and adheres to the NSA's protections and that those protections ensure fairness and prevent unexpected medical costs.

103. These representations are made in trade and commerce and are intended to induce Illinois consumers and employers to purchase and maintain HCSC-insured or administered health coverage.

104. The NSA establishes a mandatory and binding IDR process to determine payment amounts for certain out-of-network services and reflects strong public policy designed to protect consumers and promote marketplace stability.

105. Despite these representations, HCSC has adopted, implemented, and maintained a centralized policy and practice of refusing to timely pay, or refusing to pay at all, binding IDR awards.

106. The IDR Awards for which PHI seeks recovery are identified in Exhibits A and B. For each of these awards, a certified IDR entity issued a final and binding determination selecting PHI's offer and establishing the amount owed. HCSC has failed and refuses to remit payment in accordance with the binding determination.

107. Upon information and belief, HCSC's refusal to honor IDR award is not isolated or inadvertent but constitutes a pattern and practice directed from Illinois, affecting multiple providers, multiple plans, and multiple claims.

108. Upon information and belief, HCSC has implemented corporate policies, procedures, internal directives, or payment review practices originating from its Illinois offices that delay, deny, or disregard payment of binding IDR awards.

109. Such conduct reflects a systemic business practice rather than a mere contractual dispute.

110. HCSC's conduct implicates consumer protection concerns and affects the market generally. Illinois consumers and employers purchase HCSC-insured or administered health plans with the reasonable expectation that HCSC will comply with federal law, including honoring binding IDR determinations.

111. HCSC's centralized refusal to pay IDR awards undermines the reliability of federally mandated consumer protections, distorts the value of the insurance products marketed in Illinois, and threatens provider participation necessary to ensure access to emergency and other covered services.

112. By systematically disregarding binding IDR determinations, HCSC creates a risk that providers will withdraw from serving members of HCSC-administered plans or limit availability of services, thereby harming Illinois consumers and the healthcare marketplace.

113. HCSC's conduct therefore has a direct and substantial nexus to consumer protection concerns in Illinois and is not a private dispute limited to sophisticated commercial actors.

114. HCSC's conduct is unfair within the meaning of the ICFA because it offends the strong public policy embodied in the NSA, which mandates binding resolution of payment disputes to ensure stability and protect consumers.

115. HCSC's conduct is oppressive because providers are prohibited from balance billing patients for amounts beyond those permitted by federal law and therefore must absorb the economic harm resulting from HCSC's refusal to comply with binding IDR determinations.

116. HCSC's conduct causes substantial injury. PHI has suffered economic loss in the form of the unpaid IDR awards identified in Exhibits A and B. In addition, HCSC's conduct undermines consumer confidence in statutory protections and destabilizes the healthcare reimbursement system upon which Illinois consumers depend.

117. HCSC's conduct is deceptive because it publicly represents compliance with and support for NSA protections while internally implementing a policy of nonpayment that is inconsistent with those representations.

118. PHI has suffered actual damages as a direct and proximate result of HCSC's unfair and deceptive acts and practices in an amount equal to the unpaid IDR Awards identified in Exhibits A and B, together with additional consequential damages to be proven at trial.

119. HCSC's conduct was willful and knowing, entitling PHI to actual damages, attorneys' fees, costs, and all other relief available under the ICFA. PHI has suffered substantial injury and an ascertainable loss of money as a result of HCSC's actions. PHI seeks to recover actual, compensatory, consequential, and punitive damages under the ICFA, and attorneys' fees and costs under 815 ILCS 505/10a(c), pre- and post-judgment interest, and injunctive relief prohibiting HCSC from engaging in the unfair and deceptive practices described above.

VI. MOTION TO CONFIRM IDR AWARDS

120. PHI incorporates by reference the allegations of the preceding paragraphs.

121. In the alternative to enforcing the IDR Awards through an implied right of action or as a binding arbitration award, PHI requests that the Court confirm the awards pursuant to the NSA.

122. By refusing to pay the IDR Awards at Exhibit B, HCSC is violating the NSA.

123. PHI seeks to confirm earlier judgments by IDR entities. During the IDR process, the parties' bids and supporting documentation were already considered by the IDR entities. PHI does not seek to re-litigate the outcome of these awards.

124. The NSA provides that IDR awards "shall be binding" and "shall not be subject to judicial review" (with the exception of paragraphs (1) through (4) of the FAA). Because a court does not examine the merits of IDR awards, it is not engaging in "judicial review," and the NSA does not bar confirmation of IDR awards. *Richard Agag, MD v. Cigna Health & Life Ins. Co.*, No. 3:25-CV-00498 (SRU), 2026 WL 1021213 (D. Conn. Apr. 15, 2026).

125. Therefore, in the alternative to its claim under the NSA and request for enforcement under the federal and state arbitration acts, PHI moves for judicial confirmation of the awards at Exhibit B.

VII. JURY TRIAL DEMAND

126. PHI demands a trial by jury.

VIII. PRAYER

WHEREFORE, PHI respectfully prays for judgment against HCSC for the following damages and relief:

- a. Enforcement of the IDR Awards listed on Exhibits A and B, including entering judgment for the IDR Award Balances Owed, as required by federal law under the NSA or, alternatively, the FAA or IUAA;
- b. Alternatively, a judicial order confirming the IDR Awards;
- c. With respect to the portion of IDR Awards unpaid as of the date of judgment, the amount outstanding on each IDR Award plus interest or the return on investment realized by HCSC on the amount owed for each IDR Award from the 31st day after each decision was issued until the date of judgment;
- d. Declaratory judgment that IDR Awards are binding on HCSC;
- e. Consequential damages under the ICFA;

- f. Benefits and/or equitable relief under ERISA, as set forth above;
- g. Pre- and post- judgment interest;
- h. Attorney's fees, costs of suit, and punitive damages;
- i. Equitable relief requiring HCSC to comply with the NSA by paying the IDR Award Balances Owed and by paying all future IDR awards within 30 days;
- j. Temporary and narrowly tailored equitable relief, including reporting or certification obligations, necessary to remedy HCSC's demonstrated pattern of repeated non-compliance with binding IDR determinations and to ensure prospective adherence to federal law;
- k. Declaratory judgment that IDR determinations entered in proceedings between PHI and HCSC are final and binding unless vacated and must be paid within 30 days as required by the NSA; and
- l. Any and all additional legal or equitable relief to which PHI may be entitled, and this Court deems just and proper.

Dated: May 8, 2026

Respectfully submitted,

PHI HEALTH, LLC

By: /s/ Elizabeth H. Lemoine
One of its attorneys

Elizabeth H. Lemoine (*Pro Hac Vice*)
elizabeth.lemoine@wickphillips.com
Wick Phillips Gould & Martin LLP
3131 McKinney Ave., Suite 500
Dallas, TX 75204
(214) 692-6200

Brant C. Martin (*Pro Hac Vice*)
Brant.martin@wickphillips.com
Wick Phillips Gould & Martin LLP
100 Throckmorton Street, Suite 1500
Fort Worth, TX 76102
(817) 332-7788

L. Brandon Liss (bliss@foxswibel.com)
Natalie Holden (nholden@foxswibel.com)
Fox Swibel Levin & Carroll, LLP
200 West Madison Street, Suite 3000
Chicago, IL 60606
(312) 224-1200

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was served upon all counsel of record on May 8, 2026 via CM/ECF in accordance with the Federal Rules of Civil Procedure.

/s/ Elizabeth H. Lemoine
Elizabeth H. Lemoine

EXHIBIT A

Acct No.	DISP No.	Plan	Date of Service	Date of Payment	Date of Open Negotiation	Date of Commencement of IDR	IDR Decision Date	Amount Outstanding
360557	DISP-186333	Daugherty Systems, Inc. d/b/a Daugherty Business Solutions	4/7/2022	9/20/2022	11/2/2022	12/19/2022	6/1/2023	\$413.71
360557	DISP-186332	Daugherty Systems, Inc. d/b/a Daugherty Business Solutions	4/7/2022	9/20/2022	11/2/2022	12/19/2022	10/31/2023	\$16,089.07
361538	DISP-107026	Texas Municipal League Benefits Pool	4/22/2022	7/22/2022	8/30/2022	10/18/2022	2/3/2025	\$17,754.40
413683	DISP-2896658	Walmart	6/26/2024	1/29/2025	2/14/2025	4/1/2025	4/29/2025	\$14,606.68
418520	DISP-4360423	City of Lordsburg (NM)	9/3/2024	5/9/2025	6/9/2025	7/24/2025	11/14/2025	\$45,041.85
419562	DISP-2286846	ACA Marketplace	9/18/2024	10/1/2024	11/5/2024	12/20/2024	1/23/2026	\$30,307.20
427222	DISP-2914741	ACA Marketplace	1/13/2025	1/31/2025	2/19/2025	4/3/2025	4/29/2025	\$35,845.10
427222	DISP-2914742	ACA Marketplace	1/13/2025	1/31/2025	2/19/2025	4/3/2025	4/29/2025	\$15,262.80
435500	DISP-3977045	American Maritime Officers	5/30/2025	6/17/2025	7/18/2025	9/2/2025	9/30/2025	\$12,528.83
435500	DISP-3977044	American Maritime Officers	5/30/2025	6/17/2025	7/18/2025	9/2/2025	9/30/2025	\$24,959.64
436602	DISP-4485633	Oldcastle Building Envelope	6/21/2025	9/3/2025	9/24/2025	11/7/2025	1/14/2026	\$11,689.43
443361	DISP-4762405	Omni Valve Co.	9/30/2025	10/8/2025	10/29/2025	12/15/2025	1/27/2026	\$24,930.05

\$249,428.76

EXHIBIT B

IDR dispute status: Payment Determination Made
IDR reference number: DISP-107026

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-107026** and has determined that Blue Cross Blue Shield of Texas is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$12,000.00** offered by Blue Cross Blue Shield of Texas is the appropriate out-of-network rate for the service A0431 on claim number 0202212203073570C under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health. LLC submitted an offer of \$29,754.40

Blue Cross Blue Shield of Texas submitted an offer of \$12,000.00

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services		
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual		
3	The training, experience, and quality of the medical personnel that furnished such services		
4	Ambulance vehicle type, including the clinical capability level of such vehicle		
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)		
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years		
7	Additional information submitted by a party		

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, Blue Cross Blue Shield of Texas’s offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

- Single offer and single fee received

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that PHI Health. LLC is the non-prevailing party in DISP-107026 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to Blue Cross Blue Shield of Texas by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of

this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-107026 was PHI Health. LLC. The initiating party’s . The non-initiating party was Blue Cross Blue Shield of Texas. The 90-calendar day cooling off period begins on June 29, 2023 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made
IDR reference number: DISP-2896658

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-2896658** and has determined that PHI Health, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$23,293.80** offered by PHI Health, LLC is the appropriate out-of-network rate for the service A0436 on claim number 0202427150B15780X under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health, LLC submitted an offer of \$23,293.80

BLUE CROSS BLUE SHIELD TEXAS submitted an offer of \$9,567.75

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)	X	
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	X

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health, LLC’s offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of prior contracted rates and good faith negotiations effort was of substantial weight in this adjudication. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements added significant weight in reaching a payment determination. The Initiating party's evidence supporting the population density at the point of pick-up added significant weight in reaching a payment determination. The Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination. The Initiating party's information regarding the quality and outcome measurements of the provider was of limited value in reaching a payment determination in this matter. The Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, added significant weight in reaching a payment determination. The Non-Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Non-Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that BLUE CROSS BLUE SHIELD TEXAS is the non-prevailing party in DISP-2896658 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-2896658 was PHI Health, LLC. The initiating party’s NPI is 1306289996 and TIN is 721404705. The non-initiating party was BLUE CROSS BLUE SHIELD TEXAS. The 90-calendar day cooling off period begins on April 29, 2025 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-2914742

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-2914742** and has determined that PHI Health, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$16,409.20** offered by PHI Health, LLC is the appropriate out-of-network rate for the service A0436 on claim number 02025015508389C0X under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health, LLC submitted an offer of \$16,409.20

BLUE CROSS BLUE SHIELD TEXAS submitted an offer of \$3,525.68

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)		
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	X

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health, LLC’s offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of prior contracted rates and good faith negotiations effort was of substantial weight in this adjudication. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements added significant weight in reaching a payment determination. The Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination. The Initiating party's information regarding the quality and outcome measurements of the provider was of limited value in reaching a payment determination in this matter. The Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, added significant weight in reaching a payment determination. The Non-Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Non-Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that BLUE CROSS BLUE SHIELD TEXAS is the non-prevailing party in DISP-2914742 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-2914742 was PHI Health, LLC. The initiating party’s NPI is 1306289996 and TIN is 721404705. The non-initiating party was BLUE CROSS BLUE SHIELD TEXAS. The 90-calendar day cooling off period begins on April 29, 2025 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-2914741

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-2914741** and has determined that PHI Health, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$40,125.73** offered by PHI Health, LLC is the appropriate out-of-network rate for the service A0431 on claim number 02025015508389C0X under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health, LLC submitted an offer of \$40,125.73

BLUE CROSS BLUE SHIELD TEXAS submitted an offer of \$13,054.18

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	X
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	X
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)		
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health, LLC’s offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's evidence supporting additional information added significant weight in reaching a payment determination. The Initiating party's evidence supporting prior contracted rates and good faith negotiations effort added significant weight in reaching a payment determination. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements was of substantial weight in this adjudication. The Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of the quality and outcome measurements was of substantial weight in this adjudication. The Initiating party's credible evidence of ambulance vehicle type, including clinical capabilities of vehicle, was of substantial weight in this adjudication. The Non-Initiating party's information regarding patient acuity was of limited value in reaching a payment determination in this matter. The Non-Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter. The Non-Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, and good faith negotiations effort added significant weight in reaching a payment determination.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that BLUE CROSS BLUE SHIELD TEXAS is the non-prevailing party in DISP-2914741 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-2914741 was PHI Health, LLC. The initiating party’s NPI is 1306289996 and TIN is 721404705. The non-initiating party was BLUE CROSS BLUE SHIELD TEXAS. The 90-calendar day cooling off period begins on April 30, 2025 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-3977044

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-3977044** and has determined that PHI Health, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$36,733.40** offered by PHI Health, LLC is the appropriate out-of-network rate for the service A0431 on claim number 005987298 under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health, LLC submitted an offer of \$36,733.40

American Maritime Officers Medical Plan submitted an offer of \$0.00

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)	X	
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	X

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health, LLC's offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, added significant weight in reaching a payment determination. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements added significant weight in reaching a payment determination. The Initiating party's credible evidence of prior contracted rates and good faith negotiations effort was of substantial weight in this adjudication. The Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's evidence supporting the population density at the point of pick-up added significant weight in reaching a payment determination. The Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination. The Initiating party's information regarding the quality and outcome measurements of the provider was of limited value in reaching a payment determination in this matter. The Non-Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Non-Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

The Non-Initiating Party objected to not receiving claim information for the dispute or the items or services being submitted to the incorrect issuer. However, the claim information was entered into the CMS portal and submitted to the Departments and the Non-Initiating Party in a timely manner. Therefore, the objection was overruled.

The Non-Initiating Party objected that the service(s) provided were not covered by No Surprises Act (NSA) guidelines. The Non-Initiating Party did submit a list of which items and services included in the dispute were not covered under the No Surprises Act and, for each item or service listed, an explanation as to why it is not covered under the No Surprises Act. After reviewing the objection and documentation submitted by both parties, FHAS has determined that the claim(s) are covered by NSA guidelines, and the objection was overruled.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that American Maritime Officers Medical Plan is the non-prevailing party in DISP-3977044 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-3977044 was PHI Health, LLC. The initiating party’s NPI is 1306289996 and TIN is 721404705. The non-initiating party was American Maritime Officers Medical Plan. The 90-calendar day cooling off period begins on September 30, 2025 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-3977045

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-3977045** and has determined that PHI Health, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$15,622.62** offered by PHI Health, LLC is the appropriate out-of-network rate for the service A0436 on claim number 005987298 under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health, LLC submitted an offer of \$15,622.62

American Maritime Officers Medical Plan submitted an offer of \$0.00

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)	X	
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	X

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health, LLC's offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, added significant weight in reaching a payment determination. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements added significant weight in reaching a payment determination. The Initiating party's credible evidence of prior contracted rates and good faith negotiations effort was of substantial weight in this adjudication. The Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's evidence supporting the population density at the point of pick-up added significant weight in reaching a payment determination. The Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination. The Initiating party's information regarding the quality and outcome measurements of the provider was of limited value in reaching a payment determination in this matter. The Non-Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Non-Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

The Non-Initiating Party objected that the Initiating Party had not submitted the open negotiation form timely. However, FHAS reviewed the timeline and found the Initiating Party proceeded within CMS guidelines. Therefore, the objection is overruled.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that American Maritime Officers Medical Plan is the non-prevailing party in DISP-3977045 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-3977045 was PHI Health, LLC. The initiating party’s NPI is 1306289996 and TIN is 721404705. The non-initiating party was American Maritime Officers Medical Plan. The 90-calendar day cooling off period begins on September 30, 2025 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-4360423

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-4360423** and has determined that PHI Health, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$50,331.96** offered by PHI Health, LLC is the appropriate out-of-network rate for the service A0436 on claim number 0202426450290N40X01 under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health, LLC submitted an offer of \$50,331.96

Blue Cross Blue Shield of New Mexico submitted an offer of \$9,749.20

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	X
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	X
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)	X	
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health, LLC's offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's credible evidence of ambulance vehicle type, including clinical capabilities of vehicle, was of substantial weight in this adjudication. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements was of substantial weight in this adjudication. The Initiating party's evidence supporting prior contracted rates and good faith negotiations effort added significant weight in reaching a payment determination. The Initiating party's evidence supporting additional information added significant weight in reaching a payment determination. The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's evidence supporting the population density at the point of pick-up added significant weight in reaching a payment determination. The Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of the quality and outcome measurements was of substantial weight in this adjudication. The Non-Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, and good faith negotiations effort added significant weight in reaching a payment determination. The Non-Initiating party's information regarding patient acuity was of limited value in reaching a payment determination in this matter. The Non-Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has

determined that Blue Cross Blue Shield of New Mexico is the non-prevailing party in DISP-4360423 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-4360423 was PHI Health, LLC. The initiating party’s NPI is 1326094020 and TIN is 721404705. The non-initiating party was Blue Cross Blue Shield of New Mexico. The 90-calendar day cooling off period begins on November 14, 2025 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-4485633

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-4485633** and has determined that PHI Health LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$17,471.22** offered by PHI Health LLC is the appropriate out-of-network rate for the service A0436 on claim number 0202517650058W30X under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health LLC submitted an offer of \$17,471.22

Blue Cross Blue Shield of Texas submitted an offer of \$5,781.79

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	X
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)	X	
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	X

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health LLC's offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, added significant weight in reaching a payment determination. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements added significant weight in reaching a payment determination. The Initiating party's credible evidence of prior contracted rates and good faith negotiations effort was of substantial weight in this adjudication. The Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's credible evidence of the population density at the point of pick-up was of substantial weight in this adjudication. The Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination. The Initiating party's information regarding the quality and outcome measurements of the provider was of limited value in reaching a payment determination in this matter. The Non-Initiating party's information regarding ambulance vehicle type, including clinical capabilities of vehicle, and good faith negotiations effort was of limited value in reaching a payment determination in this matter. The Non-Initiating party's documentation regarding additional information was of limited value in reaching a payment determination in this matter. The Non-Initiating party's evidence supporting the QPA added significant weight in reaching a payment determination.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

The Non-Initiating Party objected to the "cooling-off" period applying to the disputed claim(s). The Non-Initiating Party should have submitted information regarding the following:

- the dispute number for the payment determination that initiated the 90-calendar-day cooling-off period and
 - a copy of the payment determination that initiated the 90-calendar-day cooling-off period
- However, the Initiating Party should have submitted documentation regarding the following:
- Documents proving the claim was already under a previous cooling-off period
 - the previous dispute number for the cooling-off period
 - an email and/ or determination from an IDRE stating the dispute is closed for cooling-off, and
 - the date which the cooling-off period began and ended
 - Proof of resubmission due to incorrect batching
- After reviewing the documentation submitted, FHAS has determined that the "cooling-off" period does not apply, and the objection is overruled.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that Blue Cross Blue Shield of Texas is the non-prevailing party in DISP-4485633 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-4485633 was PHI Health LLC. The initiating party’s NPI is 1306289996 and TIN is 721404705. The non-initiating party was Blue Cross Blue Shield of Texas. The 90-calendar day cooling off period begins on January 14, 2026 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-2286846

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-2286846** and has determined that PHI Health, LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$32,602.38** offered by PHI Health, LLC is the appropriate out-of-network rate for the service A0436 on claim number 02024265509J0160X under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health, LLC submitted an offer of \$32,602.38

Blue Cross Blue Shield of Texas submitted an offer of \$7,004.96

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	X
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	X
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)	X	
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health, LLC's offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's credible evidence of ambulance vehicle type, including clinical capabilities of vehicle, was of substantial weight in this adjudication. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements was of substantial weight in this adjudication. The Initiating party's evidence supporting prior contracted rates and good faith negotiations effort added significant weight in reaching a payment determination. The Initiating party's evidence supporting additional information added significant weight in reaching a payment determination. The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's evidence supporting the population density at the point of pick-up added significant weight in reaching a payment determination. The Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of the quality and outcome measurements was of substantial weight in this adjudication. The Non-Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, and good faith negotiations effort added significant weight in reaching a payment determination. The Non-Initiating party's information regarding patient acuity was of limited value in reaching a payment determination in this matter. The Non-Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

The Non-Initiating Party objected stating the claim(s) are subject to state law. Additional information was provided containing specific citation(s) for the state law or regulation that does not constitute a specified state law or all-payer model agreement that applies to the items or services in the dispute; and documentation that confirms that the state law does not apply, including proof of the health plan type. After review, the item(s) and/ or service(s) provided are eligible for the Federal IDR process and therefore, the objection was overruled. The Non-Initiating Party objected to the "cooling-off" period applying to the disputed claim(s). The Non-Initiating Party should have submitted information regarding the following:

- the dispute number for the payment determination that initiated the 90-calendar-day cooling-off period and
- a copy of the payment determination that initiated the 90-calendar-day cooling-off period However, the Initiating Party should have submitted documentation regarding the following:
 - Documents proving the claim was already under a previous cooling-off period
 - the previous dispute number for the cooling-off period
 - an email and/ or determination from an IDRE stating the dispute is closed for cooling-off, and
 - the date which the cooling-off period began and ended
- Proof of resubmission due to incorrect batching After reviewing the documentation submitted, FHAS has determined that the "cooling-off" period does not apply, and the objection is overruled.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that Blue Cross Blue Shield of Texas is the non-prevailing party in DISP-2286846 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health, LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-2286846 was PHI Health, LLC. The initiating party’s NPI is 1306289996 and TIN is 721404705. The non-initiating party was Blue Cross Blue Shield of Texas. The 90-calendar day cooling off period begins on January 22, 2026 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-4762405

Federal Hearings and Appeals Services, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-4762405** and has determined that PHI Health LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, Federal Hearings and Appeals Services, Inc. has determined that the out-of-network payment amount of **\$42,009.05** offered by PHI Health LLC is the appropriate out-of-network rate for the service A0431 on claim number 0202527750LK9E00X under this dispute.

Federal Hearings and Appeals Services, Inc. based this determination on a review of the following:

PHI Health LLC submitted an offer of \$42,009.05

Blue Cross Blue Shield of Texas submitted an offer of \$13,054.18

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	X
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	X
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)	X	
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party	X	

Final Determination Rationale

After a complete and careful consideration of the totality of the evidence as promulgated in 45 CFR 149.510(c)(4) which does not include information on the prohibited factors described in 45 CFR 149.510(c)(4)(v), and after applying the No Surprises Act statutory provisions, PHI Health LLC's offer best represents the value of the services that are the subject of this unique payment determination.

Both the Prevailing Party and the Non-Prevailing Party submitted an offer and credible information representing their valuation of the service(s) provided. FHAS found that the Prevailing Party's offer best represents the value of the out-of-network service(s) due to the submitted, credible information for the following factors:

The Initiating party's credible evidence of ambulance vehicle type, including clinical capabilities of vehicle, was of substantial weight in this adjudication. The Initiating party's evidence supporting the level of training and experience and/ or the quality and outcome measurements was of substantial weight in this adjudication. The Initiating party's evidence supporting prior contracted rates and good faith negotiations effort added significant weight in reaching a payment determination. The Initiating party's evidence supporting additional information added significant weight in reaching a payment determination. The Initiating party's credible evidence of patient acuity was of substantial weight in this adjudication. The Initiating party's evidence supporting the population density at the point of pick-up added significant weight in reaching a payment determination. The Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter. The Initiating party's credible evidence of the quality and outcome measurements was of substantial weight in this adjudication. The Non-Initiating party's evidence supporting ambulance vehicle type, including clinical capabilities of vehicle, and good faith negotiations effort added significant weight in reaching a payment determination. The Non-Initiating party's information regarding patient acuity was of limited value in reaching a payment determination in this matter. The Non-Initiating party's information regarding the QPA was of limited value in reaching a payment determination in this matter.

Please note that while all factors are reviewed as required under 45 CFR 149.510(c)(4), the submitted evidence and information associated with the aforementioned factors demonstrated the prevailing party's offer best represents the value of the out-of-network service(s) in this particular case.

The Non-Initiating Party objected to the "cooling-off" period applying to the disputed claim(s). The Non-Initiating Party should have submitted information regarding the following:

- the dispute number for the payment determination that initiated the 90-calendar-day cooling-off period and
 - a copy of the payment determination that initiated the 90-calendar-day cooling-off period
- However, the Initiating Party should have submitted documentation regarding the following:
- Documents proving the claim was already under a previous cooling-off period
 - the previous dispute number for the cooling-off period
 - an email and/ or determination from an IDRE stating the dispute is closed for cooling-off, and
 - the date which the cooling-off period began and ended
 - Proof of resubmission due to incorrect batching
- After reviewing the documentation submitted, FHAS has determined that the "cooling-off" period does not apply, and the objection is overruled.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. Federal Hearings and Appeals Services, Inc. has determined that Blue Cross Blue Shield of Texas is the non-prevailing party in DISP-4762405 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-4762405 was PHI Health LLC. The initiating party’s NPI is 1306289996. The non-initiating party was Blue Cross Blue Shield of Texas. The 90-calendar day cooling off period begins on January 27, 2026 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact Federal Hearings and Appeals Services, Inc.. Include your IDR Reference number referenced above.

Thank you,

Federal Hearings and Appeals Services, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-186332

National Medical Reviews, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-186332** and has determined that PHI Health LLC is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, National Medical Reviews, Inc. has determined that the out-of-network payment amount of **\$29,754.40** offered by PHI Health LLC is the appropriate out-of-network rate for the service A0431 on claim number 216023054090C00 under this dispute.

National Medical Reviews, Inc. based this determination on a review of the following:

PHI Health LLC submitted an offer of \$29,754.40

Blue Cross Blue Shield of Illinois submitted an offer of \$21,377.02

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle	X	
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)		
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years	X	
7	Additional information submitted by a party		

Final Determination Rationale

Both parties submitted offers to be considered by the certified IDR entity.

The Qualifying Payment Amount (QPA) was submitted by the Non-Initiating Party.

The Initiating Party submitted credible information with respect to:

The quality and outcomes measurements of the provider of air ambulance services that furnished the services.

The acuity of the condition of the participant, beneficiary, or enrollee receiving the services, or the complexity of providing services to the participant, beneficiary, or enrollee.

The level of training, experience, and quality of medical personnel that furnished the air ambulance services.

The air ambulance vehicle type, including the clinical capability level of such vehicle.

Demonstrations of good faith efforts (or lack of thereof) made by the OON provider of air ambulance services or the plan to enter into network agreements, as well as contracted rates between the provider and the plan during the previous 4 plan years.

The Non-Initiating Party submitted credible information with respect to:

The QPA

After a complete and careful consideration of the offers made by the parties, the QPA, and other credible additional information submitted, and after applying the No Surprises Act statutory provisions, the Initiating Party's offer best represents the value of the service that is the subject of this unique payment determination. The credible information demonstrates that the Initiating Party's offer best represents the value of the air ambulance qualified IDR items or services in this unique payment determination case.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. National Medical Reviews, Inc. has determined that Blue Cross Blue Shield of Illinois is the non-prevailing party in DISP-186332 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to PHI Health LLC by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-186332 was PHI Health LLC. The initiating party’s TIN is 721404705. The non-initiating party was Blue Cross Blue Shield of Illinois. The 90-calendar day cooling off period begins on October 31, 2023 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact National Medical Reviews, Inc.. Include your IDR Reference number referenced above.

Thank you,

National Medical Reviews, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

IDR dispute status: Payment Determination Made

IDR reference number: DISP-186333

National Medical Reviews, Inc. has reviewed your Federal Independent Dispute Resolution (IDR) dispute with reference number **DISP-186333** and has determined that Blue Cross Blue Shield of Illinois is the prevailing party in this dispute.

After considering all permissible information submitted by both parties, National Medical Reviews, Inc. has determined that the out-of-network payment amount of **\$2,258.56** offered by Blue Cross Blue Shield of Illinois is the appropriate out-of-network rate for the service A0436 on claim number 216023054090C00 under this dispute.

National Medical Reviews, Inc. based this determination on a review of the following:

PHI Health LLC submitted an offer of \$6,818.70

Blue Cross Blue Shield of Illinois submitted an offer of \$2,258.56

For each of the following determination factors, an “x” in the Initiating Party and/or Non-Initiating Party column means the party provided supporting information.

	Additional Circumstances	Initiating Party	Non-Initiating Party
1	The quality and outcomes measurements of the provider that furnished such services	X	
2	The acuity of the individual receiving such services or the complexity of furnishing such services to such individual	X	
3	The training, experience, and quality of the medical personnel that furnished such services	X	
4	Ambulance vehicle type, including the clinical capability level of such vehicle		
5	Population density of the pick up location (such as urban, suburban, rural, or frontier)		
6	Demonstrations of good faith efforts (or lack of good faith efforts) made by the disputing parties to enter into network agreements and, if applicable, contracted rates between the disputing parties during the previous 4 plan years		X
7	Additional information submitted by a party	X	X

Final Determination Rationale

Both parties submitted offers to be considered by the certified Independent Dispute Resolution (IDR) entity. The Qualifying Payment Amount (QPA) was submitted by the Initiating Party.

The Initiating Party submitted information with respect to:

The level of training, experience, and quality and outcomes measurements of the Initiating Party or facility that furnished the qualified IDR item or service;

The market share held by the Initiating Party or facility or that of the plan or issuer in the geographic region in which the qualified IDR item or service was provided;

The acuity of the participant, beneficiary, or enrollee receiving the qualified IDR item or service, or the complexity of furnishing the qualified IDR item or service to the participant, beneficiary, or enrollee; and

Additional information that is credible and relates to the offer submitted by either party and does not include information on factors that are prohibited by 45 CFR 149.510 (c) (v).

The Non-Initiating Party submitted credible information with respect to:

Demonstration of good faith efforts (or lack thereof) made by the provider or facility or the plan or issuer to enter into network agreements with each other, and, if applicable, contracted rates between the provider or facility, as applicable, and the plan or issuer, as applicable, during the previous 4 plan years; and

Additional information that is credible and relates to the offer submitted by either party and does not include information on factors that are prohibited by 45 CFR 149.510 (c) (v).

After a complete and careful consideration of the offers made by the parties, the QPA, and other credible additional information submitted, and after applying the No Surprises Act statutory provisions, the Non-Initiating Party offer best represents the value of the service that is the subject of this unique payment determination.

Both the Initiating Party and the Non-Initiating Party submitted credible information. The information demonstrates that the QPA does not adequately take into account the acuity of the member, the complexity of furnishing the qualified IDR service or the provider's level of training, experience, and quality of outcome measurements with respect to the services provided, the market share of the Non-Initiating Party or the Initiating Party's good faith efforts to enter into a network agreement.

Therefore, the offer of the Non-Initiating Party best represents the value of the services that are the subject of this payment determination.

Next Step:

If any amount is due to either party, it must be paid **not later than 30 calendar days** after the date of this notification, as follows:

- **A plan, issuer, or Federal Employees Health Benefits (FEHB) Program carrier owes a payment to a non-participating provider of air ambulance services**, when the amount of the offer selected by the certified IDR entity exceeds the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider, and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.
- **A non-participating provider of air ambulance services owes a refund to a plan, issuer, or FEHB carrier** when the offer selected by the certified IDR entity is less than the sum of 1) any initial payment the plan, issuer, or FEHB carrier has paid to the non-participating provider and 2) any cost sharing paid or owed by the participant, beneficiary, or enrollee.

NOTE: The non-prevailing party is ultimately responsible for the certified IDR entity fee, which is retained by the certified IDR entity for the services performed. National Medical Reviews, Inc. has determined that PHI Health LLC is the non-prevailing party in DISP-186333 and is responsible for paying the certified IDR entity fee. The certified IDR entity fee that was paid by the prevailing party will be returned to Blue Cross Blue Shield of Illinois by the certified IDR entity within 30 business days of the date of this notification.

Pursuant to the Federal Employees Health Benefits Act at 5 U.S.C. 8902(p), Internal Revenue Code sections 9816(c)(5)(E) and 9817(b)(5)(D), Employee Retirement Income Security Act sections 716(c)(5)(E) and 717(b)(5)(D), and Public Health Service Act sections 2799A-1(c)(5)(E) and 2799A-2(b)(5)(D), and their implementing regulations at 5 CFR 890.114, 26 CFR 54.9816-8T (c)(4)(vii), 29 CFR 2590.716-8(c)(4)(vii) and 45 CFR 149.510(c)(4)(vii), this determination is legally binding unless there is fraud or evidence of intentional misrepresentation of material facts to the certified IDR entity by any party regarding the dispute.

The party that initiated the Federal IDR Process may not submit a subsequent Notice of IDR Initiation involving the same other party with respect to a claim for the same or similar service that was the subject of this dispute during the 90-calendar-day suspension period following the date of this email, also referred to as the “cooling off” period.

If the initiating party was a provider, the provider is identified by the National Provider Identifier (NPI) or Taxpayer Identification Number (TIN). During the cooling off period, the provider may not submit a subsequent Notice of IDR Initiation involving the same non-initiating party with respect to a claim billed under the same NPI or TIN for the same or similar service.

The initiating party with respect to dispute number DISP-186333 was PHI Health LLC. The initiating party’s TIN is 721404705. The non-initiating party was Blue Cross Blue Shield of Illinois. The 90-calendar day cooling off period begins on June 1, 2023 . Please retain this information for your records.

If the end of the open negotiation period for such service falls during the cooling off period, either party may submit a Notice of IDR Initiation within 30 business days following the end of the cooling off period, as opposed to the standard 4-business-day period following the end of the open negotiation period. This 30-business-day period begins on the day after the last day of the cooling off period.

Resources

Visit the [No Surprises website](#) for additional IDR resources.

Contact information

For questions, contact National Medical Reviews, Inc.. Include your IDR Reference number referenced above.

Thank you,

National Medical Reviews, Inc.

Privileged and Confidential: The information contained in this e-mail message, including any attachments, is intended only for the personal and confidential use of the intended recipient(s) and may contain confidential and privileged information as well as information protected by the Privacy Act of 1974. If the reader of this message is not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, distribution, or copying of this message is strictly prohibited. If you have received this communication in error, please immediately contact the sender by reply e-mail and delete all copies of the original message.

EXHIBIT C



ACCOUNT 360557

Flight # 22-017821

PATIENT CONSENT, DISCLOSURE, AND ASSIGNMENT OF BENEFITS

In consideration for my receiving emergency transport and treatment from PHI Health, LLC d/b/a PHI Air Medical ("Provider"), I hereby agree to the following terms and conditions in this Patient Consent, Disclosure, and Assignment of Benefits ("Consent and Assignment"):

- 1) **Consent to Treatment:** I consent to transport and treatment by Provider including the administration of blood products and any other treatment deemed necessary in the judgment of the medical crew (the "Services").
- 2) **Assignment of Insurance Benefit:** I hereby assign to Provider the amounts to which I am entitled from any applicable health insurance or other benefit plans, including but not limited to Medicare, Medicaid and any commercial plan (collectively, "Benefit Plans") as a result of my transport and treatment by Provider until Provider has been fully paid. I hereby authorize Provider to submit claims, on my behalf, to the Benefit Plan (or its administrator). I also hereby instruct my Benefit Plan (or its administrator) to pay Provider directly for the Services rendered to me. I acknowledge that my assignment to Provider of these benefits does not relieve me of my responsibility to pay the total amount due to Provider for the Services, and I agree to pay such amount to Provider.
- 3) **Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to process my claim to my Benefit Plan (or its administrator); or (2) Process Benefit Plan claims generated in the course of examination or treatment by Provider. **This Consent and Assignment will remain in effect until revoked by me in writing.**
- 4) **Authorized Representative:** I hereby designate and authorize Provider, to the full extent permissible under law and under any applicable Benefit Plan including any ERISA plan, to act as my Authorized Representative and to exercise: (1) the right and ability to act on my behalf in connection with any claim, right or cause of action that I may have under such Benefit Plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said Benefit Plan (including but not limited to, the right to act on my behalf in respect to a Benefit Plan governed by the provisions of ERISA as provided in 29 C.F.R. 425603031(b)(4)) with respect to any healthcare expense incurred as a result of the Services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Consent and Assignment shall be as effective and valid as the original.
- 5) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other Benefit Plans have been obtained. I recognize that I am responsible for any balance not paid by my Benefit Plan for any reason. I agree to fully cooperate with Provider in contesting any Benefit Plan denial with respect to the Services including executing any documents necessary to authorize Provider to contest any Benefit Plan denial.
- 6) **Guarantee of Payment and Assignment of Benefits:** I agree to pay Provider's charges for the Services, including but not limited to any co-payments, deductibles, or other expenses that are not covered by any Benefit Plan. All charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 12% per annum. Up to the full amount of the charges for the Services and any attorney's fees and costs related to the recovery of same, I assign and transfer to Provider all my rights in and to: (a) all insurance benefits and other Benefit Plans (whether such insurance or Benefit Plans are owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the medical condition necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the medical condition which necessitated the Services. In the event any such proceeds are paid directly to me, I agree to pay them promptly to Provider to the extent of any unpaid charges.
- 7) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal belongings brought into the medical transport, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.
- 8) **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider's Notice of Privacy Practices ("NPP"), which contains additional information about the use of my PHI. The NPP is also available on Provider's website (<http://www.phiairmedical.com>).
- 9) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for obtaining police reports and other data related to the accident or incident for which Services were provided.
- 10) **Attorney's Fees:** If Provider is required to bring any action at law or equity to enforce the above terms, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred.
- 11) **Patient Acknowledgement:** The undersigned patient or patient representative acknowledges that he/she has read and understands the above terms, has had an opportunity to ask any questions, has received satisfactory answers thereto and freely and voluntarily consents to the terms hereof as evidenced by my signature below.

Patient's Signature: _____ Print Name (required): Baby Boy _____ Date: 04-07-2022

Patient's condition is such that he/she is physically or mentally incapable of signing then an authorized representative can sign:
 Reason patient cannot sign: Pt is a minor
(Explanation required whenever patient does not or cannot sign)

Authorized Representative Signature: [Signature] Printed name: _____ Date: 04-07-2022
 Please indicate the relationship of the authorized representative: the patient's legal guardian; a relative or other person who receives governmental benefits on the patient's behalf; a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; or Other: define: _____

Crew Member's Signature: The undersigned crewmember attests that the patient is physically and/or mentally incapable of signing:
 AND no authorized representative is available or willing to sign: _____ Printed Name (Required): _____
 AND Facility Signature: The above-named patient was received by: _____ Printed name/discipline: _____
 Date & Time of Sign over: Date: _____ Time: _____ Facility name and unit: _____

Signing of this form by personnel other than the patient or an authorized representative does not constitute acceptance of any financial responsibility.

Facility Medical Record/patient ID Number: _____

PHI Health, LLC d/b/a PHI Air Medical - Notice of Privacy Practices (NPP)

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU referred to as "Protected Health Information" or "PHI" may be used and disclosed and how you can obtain access to this information. Please review carefully. PHI Health, LLC d/b/a PHI Air Medical (also referred to herein as "we", "us", or "our") is required by law to protect the privacy of your PHI, to provide you with this Notice describing our legal duties and privacy practices, to follow the terms of this Notice, and to notify you of any breach of your unsecured PHI.

How We May Use and Disclose Your PHI. We may use and disclose your PHI without your authorization for the following purposes:

- **Treatment, Payment, and Health Care Operations.** We may use and disclose PHI (1) for your medical care and treatment (ex: making disclosures to hospitals, physicians, and other persons who are involved in your care); (2) to bill and get payment for services (ex: making disclosures to your health insurance plan so that payment may be collected from you, your insurance company, or a third party for the transport services we provide); and (3) for operations of our organization (ex: using information about you for medical transport operations, which include activities necessary to run the medical transport company and make sure that you receive quality care).
- **Fundraising Activities.** We may use your PHI to contact you in an effort to raise money for PHI Air Medical, ("provider") and our operations. If you do not want us to contact you for fundraising efforts, you may opt out.
- **Individuals Involved in Your Care or Payment for Your Care.** We may disclose PHI to a family member or friend who is involved in your medical care or payment for your care.
- **Health-Related Products and Services.** We may use or disclose your PHI to tell you about health-related products or services, or to recommend possible treatment alternatives that may be of interest to you.
- **Disaster Relief Efforts.** We may disclose PHI to entities assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- **Research.** We may use PHI to contact you to find out if you may be interested in participating in a particular research study.
- **As Required By Law.** We will disclose PHI when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health and Safety.** We may use and disclose PHI, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Organ & Tissue Donation.** If you are a donor, we may release PHI to organ or tissue procurement organizations as necessary to facilitate organ or tissue donation and transplantation.
- **Workers' Compensation.** We may release PHI to workers' compensation programs or other similar programs.
- **Public Health Disclosures.** We may disclose PHI to public health agencies for preventing or controlling disease or injury, or reporting the abuse or neglect of children, elders, and dependent adults.
- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities such as audits, investigations, inspections and licensure.
- **Law Enforcement.** We may disclose PHI under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Lawsuits and Disputes.** We may disclose PHI in response to a court or administrative order, or a subpoena, discovery request, or other lawful process in certain circumstances.
- **Coroners, Medical Examiners and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director as necessary to carry out their duties.
- **Specialized Government Functions.** We may disclose PHI as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Other Uses of Medical Information.** Other uses and disclosures of PHI not covered in this Notice will be made only with your written permission. Uses and disclosures for marketing and disclosures that would be a sale of medical information require your written authorization. You may revoke a written authorization to disclose your information at any time and we will stop use and disclosure for the reasons covered in your written permission. You understand that we are unable to take back any disclosures that we may have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Your Medical Information. You have the right to inspect or obtain a paper or electronic copy of your PHI, with certain exceptions. You have the right to request an amendment of your PHI if you believe your PHI is incorrect or incomplete. We may deny your request if you ask us to amend PHI that is accurate and complete, or is not part of the PHI kept by or for us. You have the right to an accounting of disclosures of your PHI that we have made, other than for treatment, payment or health care operations, and other exceptions permitted under federal law. You have the right to request that we follow special restrictions when using or disclosing your PHI for treatment, payment or health care operations. However, in most cases we are not required to agree to your request. We will agree to the requested restriction as required by law if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the PHI pertains solely to a health care item or service for which you, or someone other than your health plan on your behalf, has paid us in full. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. The list may also exclude certain other disclosures, such as for national security purposes. You have the right to receive a paper copy of this Notice at any time upon written request. If you pay for a service or health care item out-of-pocket and in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure this person has this authority and can act for you before we take any action.

Breach of PHI. We will notify you if a reportable breach of your unsecured PHI is discovered. Notification will be made to you no later than 60 days from the date the breach is discovered, and will include a brief description of how the breach occurred, the PHI involved and contact information for you to ask questions.

Questions or Complaints. If you have any questions or complaints about this Notice, or if you believe your privacy rights have been violated, you may contact us and/or file a complaint with PHI Health, LLC d/b/a PHI Air Medical by sending a letter to the HIPAA Privacy Official at 2800 N 44th Street, Suite 800 Phoenix Arizona 85008 or calling 602-224-3500. You may also file a complaint with the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, or visiting www.hhs.gov/ocaprivacy/hipaa/complaints. You will not be penalized for filing a complaint.

Changes to This Notice. We reserve the right to change this Notice and make the revised Notice effective for PHI we already have about you as well as any PHI we receive in the future. If we change our Notice, you may see a copy of the revised Notice on the PHI Air Medical website:

<http://www.phiairmedical.com>.



ACCOUNT 361538

Flight # 22-01290

PATIENT CONSENT, DISCLOSURE, AND ASSIGNMENT OF BENEFITS

As a condition of receiving emergency transport and treatment by PHI Air Medical, L.L.C., I hereby agree to the following:

- 1) **Consent to Treatment:** I consent to transport and treatment by PHI Air Medical, L.L.C. ("Provider") including the administration of blood products and any other treatment deemed necessary in the judgment of the medical crew (the "Services").
- 2) **Assignment of Insurance Benefits:** I hereby assign all applicable health insurance or other benefit plans, including but not limited to Medicare, Medicaid and any commercial plan (collectively, "Benefit Plans") to which I am entitled to Provider. I hereby authorize Provider to submit claims, on my behalf, to the Benefit Plan (or its administrator). I also hereby instruct my Benefit Plan (or its administrator) to pay Provider directly for Services rendered to me. To the extent that my current Benefit Plan prohibits direct payment or assignment to Provider, I hereby instruct and direct my Benefit Plan (or its administrator) to provide documentation of such prohibition upon request. I am fully aware that having Benefit Plan coverage does not absolve me of my responsibility to ensure that my bills for Professional Services from Provider are paid in full and I agree to make such payment.
- 3) **Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to process my claim to my Benefit Plan (or its administrator); or (2) process Benefit Plan claims generated in the course of examination or treatment. **This Consent and Assignment will remain in effect until revoked by me in writing.**
- 4) **Authorized Representative:** I hereby designate and authorize Provider, to the full extent permissible under law and under any applicable Benefit Plan, including any ERISA plan, to act as my Authorized Representative and to exercise: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have under such Benefit Plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said Benefit Plan (including but not limited to, the right to act on my behalf in respect to a Benefit Plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.
- 5) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other Benefit Plans have been obtained. I recognize that I am responsible for any balance not paid by my Benefit Plan for any reason. I agree to sign any documents necessary to authorize Provider to contest any Benefit Plan denial.
- 6) **Guarantee of Payment and Assignment of Benefits:** I agree to pay Provider's charges for the Services, including but not limited to any co-payments, deductibles or other expenses not covered by any Benefit Plan. All charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 12% per annum. I assign and transfer to Provider all my rights in and to: (a) all insurance benefits and other Benefit Plans (whether such insurance or Benefit Plans are owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the injury necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the injury or medical condition which necessitated the Services. Performed in the future. In the event any such proceeds are paid directly to me, I agree to pay them promptly to Provider.
- 7) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal belongings brought into the ambulance, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.
- 8) **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider's Notice of Privacy Practices.
- 9) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for obtaining police reports and other data related to the accident or incident for which Services were provided.
- 10) **Attorney's Fees:** If any action at law or inequity is brought to enforce this Agreement, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred. The undersigned has read this Agreement, has had an opportunity to ask any questions I have, has received satisfactory answers thereto and enters into it voluntarily.

Patient's Signature: [Signature] Print Name (required) [Redacted] Date (required): 04-22-2022

Patient's condition is such that he/she is physically or mentally incapable of signing then an authorized representative can sign: Reason patient cannot sign:

(Explanation required whenever patient does not or cannot sign)

Authorized Representative Signature: _____ Printed name (legibly) _____ Date: _____

Please indicate the relationship of the authorized representative: the patient's legal guardian; a relative or other person who receives governmental benefits on the patient's behalf; a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; or Other: define: _____

Crew Member's Signature: The undersigned crewmember attests that the patient is physically and/or mentally incapable of signing

AND no authorized representative is available or willing to sign [Signature] Printed Name (Required): Tennie Whyte RN

AND Facility Signature: The above-named patient was received by: [Signature] Printed name/discipline: Mike Noland RN

Date & Time of Sign over: Date: 04-22-2022 Time: 14:54 Facility name: Longview Regional Medical Center

Unit: ICU

Signing of this form by personnel other than the patient or an authorized representative does not constitute acceptance of any financial responsibility.

Facility Medical Record/patient ID Number: 07671-91



ACCOUNT 413683

Flight # 24-02110 A B C **PATIENT CONSENT, DISCLOSURE, AND ASSIGNMENT OF BENEFITS**

In consideration for my receiving emergency transport and treatment from PHI Health, LLC d/b/a PHI Air Medical ("Provider"), I hereby agree to the following terms and conditions in this Patient Consent, Disclosure, and Assignment of Benefits ("Consent and Assignment"):

- 1) **Consent to Treatment:** I consent to transport and treatment by Provider including the administration of blood products and any other treatment deemed necessary in the judgment of the medical crew (the "Services").
- 2) **Assignment of Insurance Benefit:** I hereby assign to Provider the amounts to which I am entitled from any applicable health insurance or other benefit plans, including but not limited to Medicare, Medicaid and any commercial plan (collectively, "Benefit Plans") as a result of my transport and treatment by Provider until Provider has been fully paid. I hereby authorize Provider to submit claims, on my behalf, to the Benefit Plan (or its administrator). I also hereby instruct my Benefit Plan (or its administrator) to pay Provider directly for the Services rendered to me. I acknowledge that my assignment to Provider of these benefits does not relieve me of my responsibility to pay the total amount due to Provider for the Services, and I agree to pay such amount to Provider.

I irrevocably and perpetually assign and convey to Provider any and all right, title, and interest, in and to, all legal, regulatory, statutory, equitable, declaratory, injunctive, civil enforcement, common law, contractual, beneficial, or administrative claims, causes of action, choses in action, rights, or benefits (both known and unknown) (the "Claims") that have arisen or may arise (in the past, present and/or future), under any Benefit Plan or contract (including, but not limited to, an insurance contract) to which I am a party or under which I am otherwise entitled to rights or benefits, and any statute, governmental regulation, common law, judicial or administrative opinion or order, right in equity, or fiduciary or other duty owed to me, that relates to, provides or may provide for, authorizes or may authorize payment for, or otherwise arises from the medical services I received from the Provider. This assignment and conveyance includes any and all rights to pursue or enforce the Claims, including but not limited to the right to seek prospective injunctive or declaratory relief. This assignment and conveyance constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other equitable, legal and/or administrative claims, including but not limited to claims brought under 29 U.S.C. § 1132(a)(1) and 29 U.S.C. § 1132(a)(3).

- 3) **Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to process my claim to my Benefit Plan (or its administrator); or (2) Process Benefit Plan claims generated in the course of examination or treatment by Provider.

This Consent and Assignment will remain in effect until revoked by me in writing.

- 4) **Authorized Representative:** I hereby designate and authorize Provider, to the full extent permissible under law and under any applicable Benefit Plan, including any ERISA plan, to act as my Authorized Representative and to exercise: (1) the right and ability to act on my behalf in connection with any claim, right or cause of action that I may have under such Benefit Plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said Benefit Plan (including but not limited to, the right to act on my behalf in respect to a Benefit Plan governed by the provisions of ERISA as provided in 29 C.F.R. 425603031(b)(4)) with respect to any healthcare expense incurred as a result of the Services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Consent and Assignment shall be as effective and valid as the original.
- 5) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other Benefit Plans have been obtained. I recognize that I am responsible for any balance not paid by my Benefit Plan for any reason. I agree to fully cooperate with Provider in contesting any Benefit Plan denial with respect to the Services including executing any documents necessary to authorize Provider to contest any Benefit Plan denial.

- 6) **Guarantee of Payment and Assignment of Benefits:** I agree to pay Provider's charges for the Services, including but not limited to any co-payments, deductibles, or other expenses that are not covered by any Benefit Plan. All charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 12% per annum. Up to the full amount of the charges for the Services and any attorney's fees and costs related to the recovery of same, I assign and transfer to Provider all my rights in and to: (a) all insurance benefits and other Benefit Plans (whether such insurance or Benefit Plans are owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the medical condition necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the medical condition which necessitated the Services. In the event any such proceeds are paid directly to me, I agree to pay them promptly to Provider to the extent of any unpaid charges.

- 7) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal belongings brought into the medical transport, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.

- 8) **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider's Notice of Privacy Practices ("NPP"), which contains additional information about the use of my PHI. The NPP is also available on Provider's website (<http://www.phiairmedical.com>).

- 9) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for obtaining police reports and other data related to the accident or incident for which Services were provided.

- 10) **Attorney's Fees:** If Provider is required to bring any action at law or equity to enforce the above terms, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred.

- 11) **Patient Acknowledgement:** The undersigned patient or patient representative acknowledges that he/she has read and understands the above terms, has had an opportunity to ask any questions, has received satisfactory answers thereto and freely and voluntarily consents to the terms hereof as evidenced by my signature below.

Patient's Signature:  Print Name (reqd): [REDACTED] Date (reqd): 06-26-2024

Patient's condition is such that he/she is physically or mentally incapable of signing then an authorized representative can sign: Reason patient cannot sign: _____ (Explanation required whenever patient does not or cannot sign)
Authorized Representative Signature: _____ Printed name _____ Date: _____ Please indicate the relationship of the authorized <input type="checkbox"/> representative: the patient's legal <input type="checkbox"/> guardian; a relative or other person who receives governmental benefits on the <input type="checkbox"/> patient's behalf; a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; or Other: Define: _____
Crew Member's Signature: The undersigned crewmember attests that the patient is physically and/or mentally incapable of signing: AND no authorized representative is available or willing to sign: _____ Printed Name (Reqd): _____ AND Facility Signature: The above-named patient was received by: _____ Printed name/discipline: _____ Date & Time of Sign over: Date: _____ Time: _____ Facility name and unit: _____ Unit

Signing of this form by personnel other than the patient or an authorized representative does not constitute acceptance of any financial responsibility.

Facility Medical Record/patient ID Number: 100153682



Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Effective date April 14, 2003. Revised December 11, 2017 and October 1, 2021.

PHI Health, LLC (dba PHI Air Medical) is required by law to keep your Protected Health Information private, to provide you with this Notice, to abide by its terms, and to notify you of any breach of your unsecured Protected Health Information.

How We May Use and Disclose Your Medical Information, also known as Protected Health Information or "PHI"

We may use and disclose your PHI without your authorization for:

Treatment, Payment, and Operations We may use or disclose PHI

- (1) To provide medical care and treatment (ex: coordinating information with hospitals, physicians, and other persons who are involved in your care);
- (2) To bill and get payment for services (ex: making disclosures to your health insurance plan so that payment may be collected from you, your insurance company, or a third party for the transport services we provide); and
- (3) For health care operations such as quality improvement activities, training, accreditation or to conduct business planning (ex: clinical peer review of patient transports to ensure high quality of services and safety).

We may also share PHI with other contractors or companies (called business associates) to assist us in our operations.

Family Members and Other Involved in Your Care We may disclose PHI to a family member or friend who is involved in your medical care or payment.

Fundraising Activities We may use your PHI to contact you in an effort to raise money for PHI Health, LLC and its operations. You may opt out of these efforts by contacting us.

Health-Related Products and Services We may use or disclose your PHI to tell you about health-related products or services, or to recommend possible treatment alternatives that may be of interest to you.

Disaster Relief Efforts We may disclose PHI to entities assisting in a disaster relief effort, to notify your family about your condition, status, and location.

Research We may use PHI to contact you for a particular research study.

Required By Law We will disclose PHI when required by applicable laws.

To Avert a Serious Threat to Health and Safety We may use and disclose PHI, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Organ & Tissue Donation If you are a donor, we may release PHI to organ or tissue procurement organizations to facilitate donation and transplantation.

Workers' Compensation We may release PHI to workers' compensation programs or other similar programs.

Public Health Disclosures We may disclose PHI to public health agencies for preventing or controlling disease or injury, or reporting the abuse or neglect of children, elders, and dependent adults.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities such as audits, investigations, inspections, and licensure.

Law Enforcement We may disclose PHI under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Lawsuits and Disputes We may disclose PHI in response to a court or administrative order, or a subpoena, discovery request, or other lawful process in certain circumstances.

Coroners, Medical Examiners and Funeral Directors We may disclose PHI to a coroner, medical examiner, or funeral director as necessary to carry out their duties.

Specialized Government Functions We may disclose PHI as required by military authorities or to authorized federal officials for national security.

Other Uses of Medical Information. Other uses and disclosures of PHI not covered in this Notice will be made only with your written permission. Uses and disclosures for marketing and disclosures that would be a sale of medical information require your written authorization.

Your Rights Regarding Your Medical Information

You have the right to inspect or obtain a paper or electronic copy of your PHI, with certain exceptions.

You have the right to request an amendment of your PHI if you believe it incorrect or incomplete. We may deny your request if you ask us to amend PHI that is accurate and complete or is not part of the PHI kept by or for us.

You have the right to an accounting of disclosures of your PHI that we have made, other than for treatment, payment or health care operations, and other exceptions permitted under federal law.

You have the right to request that we follow special restrictions when using or disclosing your PHI for treatment, payment, or health care operations. However, in most cases we are not required to agree to your request. We will agree to the requested restriction as required by law if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the PHI pertains solely to a health care item or service for which you, or someone other than your health plan on your behalf, has paid us in full.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. The list may also exclude certain other disclosures, such as for national security purposes.

You have the right to receive a paper copy of this Notice upon request.

If you pay for a service or health care item out-of-pocket and in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure this person has this authority and can act for you before we take any action.

You may revoke a written authorization to disclose your information at any time and we will stop use and disclosure for the reasons covered in your written permission. You understand that we are unable to take back any disclosures that we may have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Breach of PHI We will notify you if a reportable breach of your unsecured PHI is discovered. Notification will be made to you no later than 60 days from the discovery date and will include a brief description of how the breach occurred, the PHI involved, and contact information for PHI Health.

Changes to This Notice We reserve the right to change this Notice and make the revised Notice effective for PHI we already have about you as well as any PHI we receive in the future. A current copy of the Notice is available for review online at www.phiairmedical.com

Questions or Complaints If you have any questions or concerns about this Notice, or if you believe your privacy rights have been violated, please contact the **HIPAA Privacy Official** at 2800 N 44th Street, Suite 800 Phoenix, AZ 85008 or by calling 602-224-3500.

You may also file a complaint with the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C. 20201, or by visiting online at www.hhs.gov/ocr/privacy/hipaa/complaints.

PHI Health will not take action against you for filing a complaint.



ACCOUNT 436602

Flight # 24-045500 A B C

PATIENT CONSENT, DISCLOSURE, AND ASSIGNMENT OF BENEFITS

In consideration for my receiving emergency transport and treatment from PHI Health, LLC d/b/a PHI Air Medical ("Provider"), I hereby agree to the following terms and conditions in this Patient Consent, Disclosure, and Assignment of Benefits ("Consent and Assignment"):

- 1) **Consent to Treatment:** I consent to transport and treatment by Provider including the administration of blood products and any other treatment deemed necessary in the judgment of the medical crew (the "Services").
- 2) **Assignment of Insurance Benefit:** I hereby assign to Provider the amounts to which I am entitled from any applicable health insurance or other benefit plans, including but not limited to Medicare, Medicaid and any commercial plan (collectively, "Benefit Plans") as a result of my transport and treatment by Provider until Provider has been fully paid. I hereby authorize Provider to submit claims, on my behalf, to the Benefit Plan (or its administrator). I also hereby instruct my Benefit Plan (or its administrator) to pay Provider directly for the Services rendered to me. I acknowledge that my assignment to Provider of these benefits does not relieve me of my responsibility to pay the total amount due to Provider for the Services, and I agree to pay such amount to Provider.

I irrevocably and perpetually assign and convey to Provider any and all right, title, and interest, in and to, all legal, regulatory, statutory, equitable, declaratory, injunctive, civil enforcement, common law, contractual, beneficial, or administrative claims, causes of action, choses in action, rights, or benefits (both known and unknown) (the "Claims") that have arisen or may arise (in the past, present and/or future), under any Benefit Plan or contract (including, but not limited to, an insurance contract) to which I am a party or under which I am otherwise entitled to rights or benefits, and any statute, governmental regulation, common law, judicial or administrative opinion or order, right in equity, or fiduciary or other duty owed to me, that relates to, provides or may provide for, authorizes or may authorize payment for, or otherwise arises from the medical services I received from the Provider. This assignment and conveyance includes any and all rights to pursue or enforce the Claims, including but not limited to the right to seek prospective injunctive or declaratory relief. This assignment and conveyance constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other equitable, legal and/or administrative claims, including but not limited to claims brought under 29 U.S.C. § 1132(a)(1) and 29 U.S.C. § 1132(a)(3).

- 3) **Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to process my claim to my Benefit Plan (or its administrator); or (2) Process Benefit Plan claims generated in the course of examination or treatment by Provider.

This Consent and Assignment will remain in effect until revoked by me in writing.

- 4) **Authorized Representative:** I hereby designate and authorize Provider, to the full extent permissible under law and under any applicable Benefit Plan, including any ERISA plan, to act as my Authorized Representative and to exercise: (1) the right and ability to act on my behalf in connection with any claim, right or cause of action that I may have under such Benefit Plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said Benefit Plan (including but not limited to, the right to act on my behalf in respect to a Benefit Plan governed by the provisions of ERISA as provided in 29 C.F.R. 425603031(b)(4)) with respect to any healthcare expense incurred as a result of the Services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Consent and Assignment shall be as effective and valid as the original.
- 5) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other Benefit Plans have been obtained. I recognize that I am responsible for any balance not paid by my Benefit Plan for any reason. I agree to fully cooperate with Provider in contesting any Benefit Plan denial with respect to the Services including executing any documents necessary to authorize Provider to contest any Benefit Plan denial.

- 6) **Guarantee of Payment and Assignment of Benefits:** I agree to pay Provider's charges for the Services, including but not limited to any co-payments, deductibles, or other expenses that are not covered by any Benefit Plan. All charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 12% per annum. Up to the full amount of the charges for the Services and any attorney's fees and costs related to the recovery of same, I assign and transfer to Provider all my rights in and to: (a) all insurance benefits and other Benefit Plans (whether such insurance or Benefit Plans are owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the medical condition necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the medical condition which necessitated the Services. In the event any such proceeds are paid directly to me, I agree to pay them promptly to Provider to the extent of any unpaid charges.

- 7) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal belongings brought into the medical transport, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.

- 8) **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider's Notice of Privacy Practices ("NPP"), which contains additional information about the use of my PHI. The NPP is also available on Provider's website (<http://www.phiairmedical.com>).

- 9) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for obtaining police reports and other data related to the accident or incident for which Services were provided.

- 10) **Attorney's Fees:** If Provider is required to bring any action at law or equity to enforce the above terms, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred.

- 11) **Patient Acknowledgement:** The undersigned patient or patient representative acknowledges that he/she has read and understands the above terms, has had an opportunity to ask any questions, has received satisfactory answers thereto and freely and voluntarily consents to the terms hereof as evidenced by my signature below.

Patient's Signature:  Print Name (reqd): [REDACTED] Date (reqd): 09-03-2024

Patient's condition is such that he/she is physically or mentally incapable of signing then an authorized representative can sign:	
Reason patient cannot sign: _____ (Explanation required whenever patient does not or cannot sign)	
Authorized Representative Signature: _____	Printed name _____ Date: _____
Please indicate the relationship of the authorized <input type="checkbox"/> representative: the patient's legal <input type="checkbox"/> guardian; a relative or other person who receives governmental benefits on the <input type="checkbox"/> patient's behalf; a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; or Other:	
Define: _____	
Crew Member's Signature: The undersigned crewmember attests that the patient is physically and/or mentally incapable of signing:	
AND no authorized representative is available or willing to sign: _____ Printed Name (Reqd): _____	
AND Facility Signature: The above-named patient was received by: _____ Printed name/discipline: _____	
Date & Time of Sign over: Date: _____ Time: _____ Facility name and unit: _____ Unit _____	

Signing of this form by personnel other than the patient or an authorized representative does not constitute acceptance of any financial responsibility.

Facility Medical Record/patient ID Number: 400046995



Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Effective date April 14, 2003. Revised December 11, 2017 and October 1, 2021.

PHI Health, LLC (dba PHI Air Medical) is required by law to keep your Protected Health Information private, to provide you with this Notice, to abide by its terms, and to notify you of any breach of your unsecured Protected Health Information.

How We May Use and Disclose Your Medical Information, also known as Protected Health Information or "PHI"

We may use and disclose your PHI without your authorization for:

Treatment, Payment, and Operations We may use or disclose PHI

- (1) To provide medical care and treatment (ex: coordinating information with hospitals, physicians, and other persons who are involved in your care);
- (2) To bill and get payment for services (ex: making disclosures to your health insurance plan so that payment may be collected from you, your insurance company, or a third party for the transport services we provide); and
- (3) For health care operations such as quality improvement activities, training, accreditation or to conduct business planning (ex: clinical peer review of patient transports to ensure high quality of services and safety).

We may also share PHI with other contractors or companies (called business associates) to assist us in our operations.

Family Members and Other Involved in Your Care We may disclose PHI to a family member or friend who is involved in your medical care or payment.

Fundraising Activities We may use your PHI to contact you in an effort to raise money for PHI Health, LLC and its operations. You may opt out of these efforts by contacting us.

Health-Related Products and Services We may use or disclose your PHI to tell you about health-related products or services, or to recommend possible treatment alternatives that may be of interest to you.

Disaster Relief Efforts We may disclose PHI to entities assisting in a disaster relief effort, to notify your family about your condition, status, and location.

Research We may use PHI to contact you for a particular research study.

Required By Law We will disclose PHI when required by applicable laws.

To Avert a Serious Threat to Health and Safety We may use and disclose PHI, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Organ & Tissue Donation If you are a donor, we may release PHI to organ or tissue procurement organizations to facilitate donation and transplantation.

Workers' Compensation We may release PHI to workers' compensation programs or other similar programs.

Public Health Disclosures We may disclose PHI to public health agencies for preventing or controlling disease or injury, or reporting the abuse or neglect of children, elders, and dependent adults.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities such as audits, investigations, inspections, and licensure.

Law Enforcement We may disclose PHI under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Lawsuits and Disputes We may disclose PHI in response to a court or administrative order, or a subpoena, discovery request, or other lawful process in certain circumstances.

Coroners, Medical Examiners and Funeral Directors We may disclose PHI to a coroner, medical examiner, or funeral director as necessary to carry out their duties.

Specialized Government Functions We may disclose PHI as required by military authorities or to authorized federal officials for national security.

Other Uses of Medical Information. Other uses and disclosures of PHI not covered in this Notice will be made only with your written permission. Uses and disclosures for marketing and disclosures that would be a sale of medical information require your written authorization.

Your Rights Regarding Your Medical Information

You have the right to inspect or obtain a paper or electronic copy of your PHI, with certain exceptions.

You have the right to request an amendment of your PHI if you believe it incorrect or incomplete. We may deny your request if you ask us to amend PHI that is accurate and complete or is not part of the PHI kept by or for us.

You have the right to an accounting of disclosures of your PHI that we have made, other than for treatment, payment or health care operations, and other exceptions permitted under federal law.

You have the right to request that we follow special restrictions when using or disclosing your PHI for treatment, payment, or health care operations. However, in most cases we are not required to agree to your request. We will agree to the requested restriction as required by law if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the PHI pertains solely to a health care item or service for which you, or someone other than your health plan on your behalf, has paid us in full.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. The list may also exclude certain other disclosures, such as for national security purposes.

You have the right to receive a paper copy of this Notice upon request.

If you pay for a service or health care item out-of-pocket and in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure this person has this authority and can act for you before we take any action.

You may revoke a written authorization to disclose your information at any time and we will stop use and disclosure for the reasons covered in your written permission. You understand that we are unable to take back any disclosures that we may have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Breach of PHI We will notify you if a reportable breach of your unsecured PHI is discovered. Notification will be made to you no later than 60 days from the discovery date and will include a brief description of how the breach occurred, the PHI involved, and contact information for PHI Health.

Changes to This Notice We reserve the right to change this Notice and make the revised Notice effective for PHI we already have about you as well as any PHI we receive in the future. A current copy of the Notice is available for review online at www.phiairmedical.com

Questions or Complaints If you have any questions or concerns about this Notice, or if you believe your privacy rights have been violated, please contact the **HIPAA Privacy Official** at 2800 N 44th Street, Suite 800 Phoenix, AZ 85008 or by calling 602-224-3500.

You may also file a complaint with the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C. 20201, or by visiting online at www.hhs.gov/ocr/privacy/hipaa/complaints.

PHI Health will not take action against you for filing a complaint.



ACCOUNT 435500

Flight # 25-01593 A B C

PATIENT CONSENT, DISCLOSURE, AND ASSIGNMENT OF BENEFITS

In consideration for my receiving emergency transport and treatment from PHI Health, LLC d/b/a PHI Air Medical ("Provider"), I hereby agree to the following terms and conditions in this Patient Consent, Disclosure, and Assignment of Benefits ("Consent and Assignment"):

- 1) **Consent to Treatment:** I consent to transport and treatment by Provider including the administration of blood products and any other treatment deemed necessary in the judgment of the medical crew (the "Services").
- 2) **Assignment of Insurance Benefit:** I hereby assign to Provider the amounts to which I am entitled from any applicable health insurance or other benefit plans, including but not limited to Medicare, Medicaid and any commercial plan (collectively, "Benefit Plans") as a result of my transport and treatment by Provider until Provider has been fully paid. I hereby authorize Provider to submit claims, on my behalf, to the Benefit Plan (or its administrator). I also hereby instruct my Benefit Plan (or its administrator) to pay Provider directly for the Services rendered to me. I acknowledge that my assignment to Provider of these benefits does not relieve me of my responsibility to pay the total amount due to Provider for the Services, and I agree to pay such amount to Provider.

I irrevocably and perpetually assign and convey to Provider any and all right, title, and interest, in and to, all legal, regulatory, statutory, equitable, declaratory, injunctive, civil enforcement, common law, contractual, beneficial, or administrative claims, causes of action, choses in action, rights, or benefits (both known and unknown) (the "Claims") that have arisen or may arise (in the past, present and/or future), under any Benefit Plan or contract (including, but not limited to, an insurance contract) to which I am a party or under which I am otherwise entitled to rights or benefits, and any statute, governmental regulation, common law, judicial or administrative opinion or order, right in equity, or fiduciary or other duty owed to me, that relates to, provides or may provide for, authorizes or may authorize payment for, or otherwise arises from the medical services I received from the Provider. This assignment and conveyance includes any and all rights to pursue or enforce the Claims, including but not limited to the right to seek prospective injunctive or declaratory relief. This assignment and conveyance constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other equitable, legal and/or administrative claims, including but not limited to claims brought under 29 U.S.C. § 1132(a)(1) and 29 U.S.C. § 1132(a)(3).

- 3) **Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to process my claim to my Benefit Plan (or its administrator); or (2) Process Benefit Plan claims generated in the course of examination or treatment by Provider.

This Consent and Assignment will remain in effect until revoked by me in writing.

- 4) **Authorized Representative:** I hereby designate and authorize Provider, to the full extent permissible under law and under any applicable Benefit Plan, including any ERISA plan, to act as my Authorized Representative and to exercise: (1) the right and ability to act on my behalf in connection with any claim, right or cause of action that I may have under such Benefit Plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said Benefit Plan (including but not limited to, the right to act on my behalf in respect to a Benefit Plan governed by the provisions of ERISA as provided in 29 C.F.R. 425603031(b)(4)) with respect to any healthcare expense incurred as a result of the Services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Consent and Assignment shall be as effective and valid as the original.
- 5) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other Benefit Plans have been obtained. I recognize that I am responsible for any balance not paid by my Benefit Plan for any reason. I agree to fully cooperate with Provider in contesting any Benefit Plan denial with respect to the Services including executing any documents necessary to authorize Provider to contest any Benefit Plan denial.

- 6) **Guarantee of Payment and Assignment of Benefits:** I agree to pay Provider's charges for the Services, including but not limited to any co-payments, deductibles, or other expenses that are not covered by any Benefit Plan. All charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 12% per annum. Up to the full amount of the charges for the Services and any attorney's fees and costs related to the recovery of same, I assign and transfer to Provider all my rights in and to: (a) all insurance benefits and other Benefit Plans (whether such insurance or Benefit Plans are owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the medical condition necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the medical condition which necessitated the Services. In the event any such proceeds are paid directly to me, I agree to pay them promptly to Provider to the extent of any unpaid charges.
- 7) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal belongings brought into the medical transport, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.
- 8) **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider's Notice of Privacy Practices ("NPP"), which contains additional information about the use of my PHI. The NPP is also available on Provider's website (<http://www.phiairmedical.com>).
- 9) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for obtaining police reports and other data related to the accident or incident for which Services were provided.
- 10) **Attorney's Fees:** If Provider is required to bring any action at law or equity to enforce the above terms, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred.
- 11) **Patient Acknowledgement:** The undersigned patient or patient representative acknowledges that he/she has read and understands the above terms, has had an opportunity to ask any questions, has received satisfactory answers thereto and freely and voluntarily consents to the terms hereof as evidenced by my signature below.

Patient's Signature:  Print Name (reqd): [REDACTED] Date (reqd): 05-30-2025

Patient's condition is such that he/she is physically or mentally incapable of signing then an authorized representative can sign:	
Reason patient cannot sign: _____ (Explanation required whenever patient does not or cannot sign)	
Authorized Representative Signature: _____	Printed name _____ Date: _____
Please indicate the relationship of the authorized <input type="checkbox"/> representative: the patient's legal <input type="checkbox"/> guardian; a relative or other person who receives governmental benefits on the <input type="checkbox"/> patient's behalf; a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; or Other:	
Define: _____	
Crew Member's Signature: The undersigned crewmember attests that the patient is physically and/or mentally incapable of signing:	
AND no authorized representative is available or willing to sign: _____ Printed Name (Reqd): _____	
AND Facility Signature: The above-named patient was received by: _____ Printed name/discipline: _____	
Date & Time of Sign over: Date: 05-30-2025 Time: 16:45 Facility name and unit: CTMFH cath lab 4 Unit _____	

Signing of this form by personnel other than the patient or an authorized representative does not constitute acceptance of any financial responsibility.

Facility Medical Record/patient ID Number: 025276744



Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Effective date April 14, 2003. Revised December 11, 2017 and October 1, 2021.

PHI Health, LLC (dba PHI Air Medical) is required by law to keep your Protected Health Information private, to provide you with this Notice, to abide by its terms, and to notify you of any breach of your unsecured Protected Health Information.

How We May Use and Disclose Your Medical Information, also known as Protected Health Information or "PHI"

We may use and disclose your PHI without your authorization for:

Treatment, Payment, and Operations We may use or disclose PHI

- (1) To provide medical care and treatment (ex: coordinating information with hospitals, physicians, and other persons who are involved in your care);
- (2) To bill and get payment for services (ex: making disclosures to your health insurance plan so that payment may be collected from you, your insurance company, or a third party for the transport services we provide); and
- (3) For health care operations such as quality improvement activities, training, accreditation or to conduct business planning (ex: clinical peer review of patient transports to ensure high quality of services and safety).

We may also share PHI with other contractors or companies (called business associates) to assist us in our operations.

Family Members and Other Involved in Your Care We may disclose PHI to a family member or friend who is involved in your medical care or payment.

Fundraising Activities We may use your PHI to contact you in an effort to raise money for PHI Health, LLC and its operations. You may opt out of these efforts by contacting us.

Health-Related Products and Services We may use or disclose your PHI to tell you about health-related products or services, or to recommend possible treatment alternatives that may be of interest to you.

Disaster Relief Efforts We may disclose PHI to entities assisting in a disaster relief effort, to notify your family about your condition, status, and location.

Research We may use PHI to contact you for a particular research study.

Required By Law We will disclose PHI when required by applicable laws.

To Avert a Serious Threat to Health and Safety We may use and disclose PHI, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Organ & Tissue Donation If you are a donor, we may release PHI to organ or tissue procurement organizations to facilitate donation and transplantation.

Workers' Compensation We may release PHI to workers' compensation programs or other similar programs.

Public Health Disclosures We may disclose PHI to public health agencies for preventing or controlling disease or injury, or reporting the abuse or neglect of children, elders, and dependent adults.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities such as audits, investigations, inspections, and licensure.

Law Enforcement We may disclose PHI under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Lawsuits and Disputes We may disclose PHI in response to a court or administrative order, or a subpoena, discovery request, or other lawful process in certain circumstances.

Coroners, Medical Examiners and Funeral Directors We may disclose PHI to a coroner, medical examiner, or funeral director as necessary to carry out their duties.

Specialized Government Functions We may disclose PHI as required by military authorities or to authorized federal officials for national security.

Other Uses of Medical Information. Other uses and disclosures of PHI not covered in this Notice will be made only with your written permission. Uses and disclosures for marketing and disclosures that would be a sale of medical information require your written authorization.

Your Rights Regarding Your Medical Information

You have the right to inspect or obtain a paper or electronic copy of your PHI, with certain exceptions.

You have the right to request an amendment of your PHI if you believe it incorrect or incomplete. We may deny your request if you ask us to amend PHI that is accurate and complete or is not part of the PHI kept by or for us.

You have the right to an accounting of disclosures of your PHI that we have made, other than for treatment, payment or health care operations, and other exceptions permitted under federal law.

You have the right to request that we follow special restrictions when using or disclosing your PHI for treatment, payment, or health care operations. However, in most cases we are not required to agree to your request. We will agree to the requested restriction as required by law if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the PHI pertains solely to a health care item or service for which you, or someone other than your health plan on your behalf, has paid us in full.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. The list may also exclude certain other disclosures, such as for national security purposes.

You have the right to receive a paper copy of this Notice upon request.

If you pay for a service or health care item out-of-pocket and in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure this person has this authority and can act for you before we take any action.

You may revoke a written authorization to disclose your information at any time and we will stop use and disclosure for the reasons covered in your written permission. You understand that we are unable to take back any disclosures that we may have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Breach of PHI We will notify you if a reportable breach of your unsecured PHI is discovered. Notification will be made to you no later than 60 days from the discovery date and will include a brief description of how the breach occurred, the PHI involved, and contact information for PHI Health.

Changes to This Notice We reserve the right to change this Notice and make the revised Notice effective for PHI we already have about you as well as any PHI we receive in the future. A current copy of the Notice is available for review online at www.phiairmedical.com

Questions or Complaints If you have any questions or concerns about this Notice, or if you believe your privacy rights have been violated, please contact the **HIPAA Privacy Official** at 2800 N 44th Street, Suite 800 Phoenix, AZ 85008 or by calling 602-224-3500.

You may also file a complaint with the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C. 20201, or by visiting online at www.hhs.gov/ocr/privacy/hipaa/complaints.

PHI Health will not take action against you for filing a complaint.



ACCOUNT 443362

Flight # 25-01821 A B C

PATIENT CONSENT, DISCLOSURE, AND ASSIGNMENT OF BENEFITS

In consideration for my receiving emergency transport and treatment from PHI Health, LLC d/b/a PHI Air Medical ("Provider"), I hereby agree to the following terms and conditions in this Patient Consent, Disclosure, and Assignment of Benefits ("Consent and Assignment"):

- 1) **Consent to Treatment:** I consent to transport and treatment by Provider including the administration of blood products and any other treatment deemed necessary in the judgment of the medical crew (the "Services").
- 2) **Assignment of Insurance Benefit:** I hereby assign to Provider the amounts to which I am entitled from any applicable health insurance or other benefit plans, including but not limited to Medicare, Medicaid and any commercial plan (collectively, "Benefit Plans") as a result of my transport and treatment by Provider until Provider has been fully paid. I hereby authorize Provider to submit claims, on my behalf, to the Benefit Plan (or its administrator). I also hereby instruct my Benefit Plan (or its administrator) to pay Provider directly for the Services rendered to me. I acknowledge that my assignment to Provider of these benefits does not relieve me of my responsibility to pay the total amount due to Provider for the Services, and I agree to pay such amount to Provider.

I irrevocably and perpetually assign and convey to Provider any and all right, title, and interest, in and to, all legal, regulatory, statutory, equitable, declaratory, injunctive, civil enforcement, common law, contractual, beneficial, or administrative claims, causes of action, choses in action, rights, or benefits (both known and unknown) (the "Claims") that have arisen or may arise (in the past, present and/or future), under any Benefit Plan or contract (including, but not limited to, an insurance contract) to which I am a party or under which I am otherwise entitled to rights or benefits, and any statute, governmental regulation, common law, judicial or administrative opinion or order, right in equity, or fiduciary or other duty owed to me, that relates to, provides or may provide for, authorizes or may authorize payment for, or otherwise arises from the medical services I received from the Provider. This assignment and conveyance includes any and all rights to pursue or enforce the Claims, including but not limited to the right to seek prospective injunctive or declaratory relief. This assignment and conveyance constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other equitable, legal and/or administrative claims, including but not limited to claims brought under 29 U.S.C. § 1132(a)(1) and 29 U.S.C. § 1132(a)(3).

- 3) **Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to process my claim to my Benefit Plan (or its administrator); or (2) Process Benefit Plan claims generated in the course of examination or treatment by Provider.

This Consent and Assignment will remain in effect until revoked by me in writing.

- 4) **Authorized Representative:** I hereby designate and authorize Provider, to the full extent permissible under law and under any applicable Benefit Plan, including any ERISA plan, to act as my Authorized Representative and to exercise: (1) the right and ability to act on my behalf in connection with any claim, right or cause of action that I may have under such Benefit Plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said Benefit Plan (including but not limited to, the right to act on my behalf in respect to a Benefit Plan governed by the provisions of ERISA as provided in 29 C.F.R. 425603031(b)(4)) with respect to any healthcare expense incurred as a result of the Services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Consent and Assignment shall be as effective and valid as the original.
- 5) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other Benefit Plans have been obtained. I recognize that I am responsible for any balance not paid by my Benefit Plan for any reason. I agree to fully cooperate with Provider in contesting any Benefit Plan denial with respect to the Services including executing any documents necessary to authorize Provider to contest any Benefit Plan denial.

- 6) **Guarantee of Payment and Assignment of Benefits:** I agree to pay Provider's charges for the Services, including but not limited to any co-payments, deductibles, or other expenses that are not covered by any Benefit Plan. All charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 12% per annum. Up to the full amount of the charges for the Services and any attorney's fees and costs related to the recovery of same, I assign and transfer to Provider all my rights in and to: (a) all insurance benefits and other Benefit Plans (whether such insurance or Benefit Plans are owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the medical condition necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the medical condition which necessitated the Services. In the event any such proceeds are paid directly to me, I agree to pay them promptly to Provider to the extent of any unpaid charges.
- 7) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal belongings brought into the medical transport, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.
- 8) **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider's Notice of Privacy Practices ("NPP"), which contains additional information about the use of my PHI. The NPP is also available on Provider's website (<http://www.phiairmedical.com>).
- 9) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for obtaining police reports and other data related to the accident or incident for which Services were provided.
- 10) **Attorney's Fees:** If Provider is required to bring any action at law or equity to enforce the above terms, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred.
- 11) **Patient Acknowledgement:** The undersigned patient or patient representative acknowledges that he/she has read and understands the above terms, has had an opportunity to ask any questions, has received satisfactory answers thereto and freely and voluntarily consents to the terms hereof as evidenced by my signature below.

Patient's Signature: UTS Print Name (reqd): [REDACTED] Date (reqd): 06-21-2025

Patient's condition is such that he/she is physically or mentally incapable of signing then an authorized representative can sign:	
Reason patient cannot sign: <u>[REDACTED]</u>	(Explanation required whenever patient does not or cannot sign)
Authorized Representative Signature: _____	Printed name _____ Date: _____
Please indicate the relationship of the authorized <input type="checkbox"/> representative: the patient's legal <input type="checkbox"/> guardian; a relative or other person who receives governmental benefits on the <input type="checkbox"/> patient's behalf; a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; or Other:	
Define: _____	
Crew Member's Signature: The undersigned crewmember attests that the patient is physically and/or mentally incapable of signing:	
AND no authorized representative is available or willing to sign: <u>[Signature]</u>	Printed Name (Reqd): <u>Mike Douglas, CFRN</u>
AND Facility Signature: The above-named patient was received by: <u>[Signature]</u>	Printed name/discipline: <u>Elizabeth H., RN</u>
Date & Time of Sign over: Date: <u>06-21-2025</u> Time: <u>20:22</u>	Facility name and unit: <u>CTMFH ER T1</u> Unit _____

Signing of this form by personnel other than the patient or an authorized representative does not constitute acceptance of any financial responsibility.

Facility Medical Record/patient ID Number: 097652929



Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Effective date April 14, 2003. Revised December 11, 2017 and October 1, 2021.

PHI Health, LLC (dba PHI Air Medical) is required by law to keep your Protected Health Information private, to provide you with this Notice, to abide by its terms, and to notify you of any breach of your unsecured Protected Health Information.

How We May Use and Disclose Your Medical Information, also known as Protected Health Information or "PHI"

We may use and disclose your PHI without your authorization for:

Treatment, Payment, and Operations We may use or disclose PHI

- (1) To provide medical care and treatment (ex: coordinating information with hospitals, physicians, and other persons who are involved in your care);
- (2) To bill and get payment for services (ex: making disclosures to your health insurance plan so that payment may be collected from you, your insurance company, or a third party for the transport services we provide); and
- (3) For health care operations such as quality improvement activities, training, accreditation or to conduct business planning (ex: clinical peer review of patient transports to ensure high quality of services and safety).

We may also share PHI with other contractors or companies (called business associates) to assist us in our operations.

Family Members and Other Involved in Your Care We may disclose PHI to a family member or friend who is involved in your medical care or payment.

Fundraising Activities We may use your PHI to contact you in an effort to raise money for PHI Health, LLC and its operations. You may opt out of these efforts by contacting us.

Health-Related Products and Services We may use or disclose your PHI to tell you about health-related products or services, or to recommend possible treatment alternatives that may be of interest to you.

Disaster Relief Efforts We may disclose PHI to entities assisting in a disaster relief effort, to notify your family about your condition, status, and location.

Research We may use PHI to contact you for a particular research study.

Required By Law We will disclose PHI when required by applicable laws.

To Avert a Serious Threat to Health and Safety We may use and disclose PHI, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Organ & Tissue Donation If you are a donor, we may release PHI to organ or tissue procurement organizations to facilitate donation and transplantation.

Workers' Compensation We may release PHI to workers' compensation programs or other similar programs.

Public Health Disclosures We may disclose PHI to public health agencies for preventing or controlling disease or injury, or reporting the abuse or neglect of children, elders, and dependent adults.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities such as audits, investigations, inspections, and licensure.

Law Enforcement We may disclose PHI under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Lawsuits and Disputes We may disclose PHI in response to a court or administrative order, or a subpoena, discovery request, or other lawful process in certain circumstances.

Coroners, Medical Examiners and Funeral Directors We may disclose PHI to a coroner, medical examiner, or funeral director as necessary to carry out their duties.

Specialized Government Functions We may disclose PHI as required by military authorities or to authorized federal officials for national security.

Other Uses of Medical Information. Other uses and disclosures of PHI not covered in this Notice will be made only with your written permission. Uses and disclosures for marketing and disclosures that would be a sale of medical information require your written authorization.

Your Rights Regarding Your Medical Information

You have the right to inspect or obtain a paper or electronic copy of your PHI, with certain exceptions.

You have the right to request an amendment of your PHI if you believe it incorrect or incomplete. We may deny your request if you ask us to amend PHI that is accurate and complete or is not part of the PHI kept by or for us.

You have the right to an accounting of disclosures of your PHI that we have made, other than for treatment, payment or health care operations, and other exceptions permitted under federal law.

You have the right to request that we follow special restrictions when using or disclosing your PHI for treatment, payment, or health care operations. However, in most cases we are not required to agree to your request. We will agree to the requested restriction as required by law if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the PHI pertains solely to a health care item or service for which you, or someone other than your health plan on your behalf, has paid us in full.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. The list may also exclude certain other disclosures, such as for national security purposes.

You have the right to receive a paper copy of this Notice upon request.

If you pay for a service or health care item out-of-pocket and in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure this person has this authority and can act for you before we take any action.

You may revoke a written authorization to disclose your information at any time and we will stop use and disclosure for the reasons covered in your written permission. You understand that we are unable to take back any disclosures that we may have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Breach of PHI We will notify you if a reportable breach of your unsecured PHI is discovered. Notification will be made to you no later than 60 days from the discovery date and will include a brief description of how the breach occurred, the PHI involved, and contact information for PHI Health.

Changes to This Notice We reserve the right to change this Notice and make the revised Notice effective for PHI we already have about you as well as any PHI we receive in the future. A current copy of the Notice is available for review online at www.phiairmedical.com

Questions or Complaints If you have any questions or concerns about this Notice, or if you believe your privacy rights have been violated, please contact the **HIPAA Privacy Official** at 2800 N 44th Street, Suite 800 Phoenix, AZ 85008 or by calling 602-224-3500.

You may also file a complaint with the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C. 20201, or by visiting online at www.hhs.gov/ocr/privacy/hipaa/complaints.

PHI Health will not take action against you for filing a complaint.



ACCOUNT 443361

Flight # 25-049856

A B C

PATIENT CONSENT, DISCLOSURE, AND ASSIGNMENT OF BENEFITS

In consideration for my receiving emergency transport and treatment from PHI Health, LLC d/b/a PHI Air Medical ("Provider"), I hereby agree to the following terms and conditions in this Patient Consent, Disclosure, and Assignment of Benefits ("Consent and Assignment"):

- 1) **Consent to Treatment:** I consent to transport and treatment by Provider including the administration of blood products and any other treatment deemed necessary in the judgment of the medical crew (the "Services").
- 2) **Assignment of Insurance Benefit:** I hereby assign to Provider the amounts to which I am entitled from any applicable health insurance or other benefit plans, including but not limited to Medicare, Medicaid and any commercial plan (collectively, "Benefit Plans") as a result of my transport and treatment by Provider until Provider has been fully paid. I hereby authorize Provider to submit claims, on my behalf, to the Benefit Plan (or its administrator). I also hereby instruct my Benefit Plan (or its administrator) to pay Provider directly for the Services rendered to me. I acknowledge that my assignment to Provider of these benefits does not relieve me of my responsibility to pay the total amount due to Provider for the Services, and I agree to pay such amount to Provider.

I irrevocably and perpetually assign and convey to Provider any and all right, title, and interest, in and to, all legal, regulatory, statutory, equitable, declaratory, injunctive, civil enforcement, common law, contractual, beneficial, or administrative claims, causes of action, choses in action, rights, or benefits (both known and unknown) (the "Claims") that have arisen or may arise (in the past, present and/or future), under any Benefit Plan or contract (including, but not limited to, an insurance contract) to which I am a party or under which I am otherwise entitled to rights or benefits, and any statute, governmental regulation, common law, judicial or administrative opinion or order, right in equity, or fiduciary or other duty owed to me, that relates to, provides or may provide for, authorizes or may authorize payment for, or otherwise arises from the medical services I received from the Provider. This assignment and conveyance includes any and all rights to pursue or enforce the Claims, including but not limited to the right to seek prospective injunctive or declaratory relief. This assignment and conveyance constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other equitable, legal and/or administrative claims, including but not limited to claims brought under 29 U.S.C. § 1132(a)(1) and 29 U.S.C. § 1132(a)(3).

- 3) **Authorization to Release Information:** I hereby authorize Provider to: (1) release any information necessary to process my claim to my Benefit Plan (or its administrator); or (2) Process Benefit Plan claims generated in the course of examination or treatment by Provider.

This Consent and Assignment will remain in effect until revoked by me in writing.

- 4) **Authorized Representative:** I hereby designate and authorize Provider, to the full extent permissible under law and under any applicable Benefit Plan, including any ERISA plan, to act as my Authorized Representative and to exercise: (1) the right and ability to act on my behalf in connection with any claim, right or cause of action that I may have under such Benefit Plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said Benefit Plan (including but not limited to, the right to act on my behalf in respect to a Benefit Plan governed by the provisions of ERISA as provided in 29 C.F.R. 425603031(b)(4)) with respect to any healthcare expense incurred as a result of the Services I received from Provider and, to the extent permissible under the law, to claim on my behalf such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Consent and Assignment shall be as effective and valid as the original.
- 5) **Insurance Certification and Authorization:** I accept responsibility for ensuring that all certifications or authorizations required by Medicare, Medicaid or any other Benefit Plans have been obtained. I recognize that I am responsible for any balance not paid by my Benefit Plan for any reason. I agree to fully cooperate with Provider in contesting any Benefit Plan denial with respect to the Services including executing any documents necessary to authorize Provider to contest any Benefit Plan denial.

- 6) **Guarantee of Payment and Assignment of Benefits:** I agree to pay Provider's charges for the Services, including but not limited to any co-payments, deductibles, or other expenses that are not covered by any Benefit Plan. All charges shall be due and payable on receipt of invoice. Unpaid accounts shall bear interest at the rate of 12% per annum. Up to the full amount of the charges for the Services and any attorney's fees and costs related to the recovery of same, I assign and transfer to Provider all my rights in and to: (a) all insurance benefits and other Benefit Plans (whether such insurance or Benefit Plans are owned by me or not) payable as a result of the injury or medical condition that necessitated the Services; (b) any and all proceeds paid or payable to me or on my behalf from any settlement, judgment or other award which is obtained as a result of the medical condition necessitating the Services; (c) any causes of action that may be assigned according to applicable State law, which I now have or may have in the future against any person or entity arising directly or indirectly from the medical condition which necessitated the Services. In the event any such proceeds are paid directly to me, I agree to pay them promptly to Provider to the extent of any unpaid charges.

- 7) **Release of Liability for Personal Valuables:** I understand and agree that Provider is not responsible for personal belongings brought into the medical transport, including, but not limited to, clothing, personal hygiene products, toiletries, dentures, glasses, prosthetic devices such as hearing aids, artificial limbs, medical assist devices, wallets, purses, credit cards, jewelry and money.

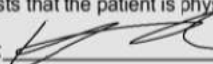

- 8) **Acknowledgment of Receipt of Notice of Privacy Practices:** I acknowledge receipt of Provider's Notice of Privacy Practices ("NPP"), which contains additional information about the use of my PHI. The NPP is also available on Provider's website (<http://www.phiairmedical.com>).

- 9) **Release of Police Reports:** I appoint Provider as my attorney in fact under applicable State law for obtaining police reports and other data related to the accident or incident for which Services were provided.

- 10) **Attorney's Fees:** If Provider is required to bring any action at law or equity to enforce the above terms, Provider shall be entitled to recover reasonable attorney's fees, court costs, and any other costs of collection incurred.

- 11) **Patient Acknowledgement:** The undersigned patient or patient representative acknowledges that he/she has read and understands the above terms, has had an opportunity to ask any questions, has received satisfactory answers thereto and freely and voluntarily consents to the terms hereof as evidenced by my signature below.

Patient's Signature:  Print Name (required): [REDACTED] Date (required): 09-30-2025

Patient's condition is such that he/she is physically or mentally incapable of signing then an authorized representative can sign: Reason patient cannot sign: <u>Unresponsive GCS3</u> <small>(Explanation required whenever patient does not or cannot sign)</small>	
Authorized Representative Signature: _____	Printed name (legibly) _____ Date: _____
Please indicate the relationship of the authorized representative: <input type="checkbox"/> the patient's legal guardian; <input type="checkbox"/> a relative or other person who receives governmental benefits on the patient's behalf; <input type="checkbox"/> a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; or Other: _____	
Define: _____	
Crew Member's Signature: The undersigned crewmember attests that the patient is physically and/or mentally incapable of signing: AND no authorized representative is available or willing to sign:  Printed Name (Required): <u>Lauren Gibson RN</u>	
AND Facility Signature: The above-named patient was received by  Printed name/discipline: <u>Alex Steiber RN</u>	
Date & Time of Sign over: Date: <u>09-30-2025</u> Time: <u>13:45</u> Facility name and unit: <u>St Davids South Austin ER</u>	

Signing of this form by personnel other than the patient or an authorized representative does not constitute acceptance of any financial responsibility.

Facility Medical Record/patient ID Number: K000932197



Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. Effective date April 14, 2003. Revised December 11, 2017 and October 1, 2021.

PHI Health, LLC (dba PHI Air Medical) is required by law to keep your Protected Health Information private, to provide you with this Notice, to abide by its terms, and to notify you of any breach of your unsecured Protected Health Information.

How We May Use and Disclose Your Medical Information, also known as Protected Health Information or "PHI"

We may use and disclose your PHI without your authorization for:

Treatment, Payment, and Operations

- We may use or disclose PHI
- (1) To provide medical care and treatment (ex: coordinating information with hospitals, physicians, and other persons who are involved in your care);
 - (2) To bill and get payment for services (ex: making disclosures to your health insurance plan so that payment may be collected from you, your insurance company, or a third party for the transport services we provide); and
 - (3) For health care operations such as quality improvement activities, training, accreditation or to conduct business planning (ex: clinical peer review of patient transports to ensure high quality of services and safety).

We may also share PHI with other contractors or companies (called business associates) to assist us in our operations.

Family Members and Other Involved in Your Care We may disclose PHI to a family member or friend who is involved in your medical care or payment.

Fundraising Activities We may use your PHI to contact you in an effort to raise money for PHI Health, LLC and its operations. You may opt out of these efforts by contacting us.

Health-Related Products and Services We may use or disclose your PHI to tell you about health-related products or services, or to recommend possible treatment alternatives that may be of interest to you.

Disaster Relief Efforts We may disclose PHI to entities assisting in a disaster relief effort, to notify your family about your condition, status, and location.

Research We may use PHI to contact you for a particular research study.

Required By Law We will disclose PHI when required by applicable laws.

To Avert a Serious Threat to Health and Safety We may use and disclose PHI, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Organ & Tissue Donation If you are a donor, we may release PHI to organ or tissue procurement organizations to facilitate donation and transplantation.

Workers' Compensation We may release PHI to workers' compensation programs or other similar programs.

Public Health Disclosures We may disclose PHI to public health agencies for preventing or controlling disease or injury, or reporting the abuse or neglect of children, elders, and dependent adults.

Health Oversight Activities We may disclose PHI to a health oversight agency for activities such as audits, investigations, inspections, and licensure.

Law Enforcement We may disclose PHI under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Lawsuits and Disputes We may disclose PHI in response to a court or administrative order, or a subpoena, discovery request, or other lawful process in certain circumstances.

Coroners, Medical Examiners and Funeral Directors We may disclose PHI to a coroner, medical examiner, or funeral director as necessary to carry out their duties.

Specialized Government Functions We may disclose PHI as required by military authorities or to authorized federal officials for national security.

Other Uses of Medical Information. Other uses and disclosures of PHI not covered in this Notice will be made only with your written permission. Uses and disclosures for marketing and disclosures that would be a sale of medical information require your written authorization.

Your Rights Regarding Your Medical Information

You have the right to inspect or obtain a paper or electronic copy of your PHI, with certain exceptions.

You have the right to request an amendment of your PHI if you believe it incorrect or incomplete. We may deny your request if you ask us to amend PHI that is accurate and complete or is not part of the PHI kept by or for us.

You have the right to an accounting of disclosures of your PHI that we have made, other than for treatment, payment or health care operations, and other exceptions permitted under federal law.

You have the right to request that we follow special restrictions when using or disclosing your PHI for treatment, payment, or health care operations. However, in most cases we are not required to agree to your request. We will agree to the requested restriction as required by law if: (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the PHI pertains solely to a health care item or service for which you, or someone other than your health plan on your behalf, has paid us in full.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate all reasonable requests. The list may also exclude certain other disclosures, such as for national security purposes.

You have the right to receive a paper copy of this Notice upon request.

If you pay for a service or health care item out-of-pocket and in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure this person has this authority and can act for you before we take any action.

You may revoke a written authorization to disclose your information at any time and we will stop use and disclosure for the reasons covered in your written permission. You understand that we are unable to take back any disclosures that we may have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Breach of PHI We will notify you if a reportable breach of your unsecured PHI is discovered. Notification will be made to you no later than 60 days from the discovery date and will include a brief description of how the breach occurred, the PHI involved, and contact information for PHI Health.

Changes to This Notice We reserve the right to change this Notice and make the revised Notice effective for PHI we already have about you as well as any PHI we receive in the future. A current copy of the Notice is available for review online at www.phiairmedical.com

Questions or Complaints If you have any questions or concerns about this Notice, or if you believe your privacy rights have been violated, please contact the **HIPAA Privacy Official** at 2800 N 44th Street, Suite 800 Phoenix, AZ 85008 or by calling 602-224-3500.

You may also file a complaint with the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C. 20201, or by visiting online at www.hhs.gov/ocr/privacy/hipaa/complaints.

PHI Health will not take action against you for filing a complaint.