Ambulance Billing Authorization Form - SUPPLIERS

Patient Name: _____ **Transport Date:** _____ **Card #** _____

The above named patient or the patient's lawful representative or surrogate for consent to treatment acknowledges that the medical care which (was) (is about to be) furnished to the patient (was) (will be) limited solely to emergency transportation and treatment. The Undersigned authorizes such medical and surgical treatment and transportation as being considered medically necessary. I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Supplier for any services provided to me by Supplier now or in the future. I understand that I am financially responsible for the services provided to me by Supplier, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Supplier any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Supplier. I authorize Supplier to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Supplier and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Supplier, now or in the future. If collection proceedings take place, any and all legal costs (including attorney fees) will be the responsibility of the patient, the patient's legal guardian(s) or the patient's estate. Supplier is not liable for any lost personal items, which are on or in the possession of the person we transport. A copy of this form is as valid as an original. Supplier means EagleMed, LLC.

SIGNATURE SECTION:

One of the following three sections MUST be completed

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____

Patient Signature or Mark

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness.

X _____

Witness Signature

_____

Witness Printed Name

If patient is physically or mentally incapable of signing, Section II must be completed.

NOTE: If patient is a minor, the parent or legal guardian is required to sign in this section.

SECTION II –-AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

☐ Representative of sending facility that furnished care.
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

X _____ _____

Representative Signature Printed Name of Representative

SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** for emergency ambulance transports, if patient was physically or mentally incapable of signing, **and** no authorized representative (as listed in Section II) was available or willing to sign on behalf of the patient at the time of service. Crew member must complete A. and have a staff member from the receiving facility sign B. If you are unable to obtain a signature in B crew member must obtain a Face sheet.

A. Ambulance Crew Member Statement (required to be completed by crew member at time of transport)

My signature below indicates that, at the time of service, none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf and it was impractical for the patient to sign because, as further detailed in the patient record, ☐ *the patient was physically or mentally incapable (includes unconscious or medicated or in the event patient expired after dispatch but prior to or upon arrival of ambulance) OR* ☐ *uninterrupted delivery of emergency care was in the patient's best interest OR*

☐*Other*_____

Name and Location of Receiving Facility: _____ Time at Receiving Facility:_____

X _____ _____

Signature of Supplier Crewmember Printed Name of Supplier Crewmember

B. Receiving Facility Representative Signature

The above-named patient was received by this facility at the date and time indicated above.

X _____ _____

Signature of Receiving Facility Representative Printed Name and Title of Receiving Facility Representative

OR Secondary Documentation

If no facility representative signature is obtained above, the ambulance crew should obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

☐ Receiving Facility Face Sheet/Admissions Record
☐ Patient Medical Record
☐ Patient Care Report (signed by representative of facility)
☐ Hospital Log or Other Similar Facility Record