

Ambulance Billing Authorization Form – SUPPLIERS

Patient Name: _____ Transport Date: _____

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 valid as an original*

Supplier means _____
(Company name including any applicable d/b/a)

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing. NOTE: if the patient is a minor, the parent or legal guardian should sign in this section. If the patient signs with an “X” or other mark, it is recommended that someone sign below as a witness.

X _____ X _____
Patient Signature or Mark Date Witness Signature Date

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

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

On the line below, explain the circumstances that make it impractical for the patient to sign:

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by _____ now or in the past, (or in the future, where permitted). By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.** Authorized representatives include **only** the following individuals:

- Patient’s legal guardian
- Relative or other person who receives social security or other governmental benefits on behalf of the patient
- Relative or other person who arranges for the patient’s treatment or exercise other responsibility for the patient’s affairs
- Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X _____
Representative Signature Date Printed Name and Address of Representative

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES: Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, and (2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (*must* be completed by crewmember at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that 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 Crewmember Date Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.**

X _____
Signature of Receiving Facility Representative Date 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 indicated that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information to the ambulance service is expressly permitted by § 164.506(c) of HIPAA.

- Receiving Facility Face Sheet / Admissions Record
- Patient Care Report (signed by representative of facility)