Ambulance Billing Authorization and Privacy Acknowledgement Form - SUPPLIERS

Patient Name: _____ Transport Date: _____

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to New Madrid County Ambulance for any services provided to me now or in the future. I understand that I am financially responsible for the services provided to me, regardless of my insurance coverage, and in some cases, may be responsible for any amount in addition to that which was paid by my insurance. I agree to immediately remit to New Madrid County Ambulance 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 New Madrid County Ambulance. I authorize New Madrid County Ambulance 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 New Madrid County Ambulance and its billing agents and/or the Centers for Medicaid 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, now or in the future. A copy of this form is valid as an original.

Privacy Practices Ackowledgement: by signing below. I acknowledge that I have received New Madrid County Ambulance, Notice of Privacy Practices.

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.

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):

- ❒ Patient's Legal Guardian ❒ Patient's Health Care Power of Attorney
- ❒ Relative or other person who receives government benifits on behalf of patient
- ❒ Relative or other person who arranges treatment or handles the patient's affairs
- ❒ Represntative of an agency or institution that furnish care, services or assistance to the patient.

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 the service.

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

My signiture 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.

Reason pt. incapable of signing: _____

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

X_____ _____
Signature of Crewmember Printed Name of 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

C. Secondary Documentation

If no facility representative signature is obtained, the ambulance crew should attempt to obain 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.

- ❒ Patient Care report (signed by representative of facility)
- ❒ Patient Medical Record
- ❒ Facility Face Sheet/Admissions Record
- ❒ Hospital Log or Other Similar Facility Record