Ambulance Billing Authorization Form – SUPPLIERS –(Revision date 07/18/2014)

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

The person signing below in section I or II only, (for himself/herself as the patient or as the legal representative, or surrogate for consent to treatment, on behalf of the patient named above): (1) acknowledges that the medical treatment and transportation (the "Services") furnished to the patient was actually received and was limited solely to emergency treatment and transportation; (2) authorizes such Services as being medically necessary; (3) authorizes and directs any holder of medical information or documentation about the patient to release such information to Supplier, its billing agents, CMS, its carriers and agents and/or any other payors or insurers as may be appropriate to determine any benefits payable for the Services or any other medical services provided to the patient by Supplier now or in the future; (4) completely assigns to Supplier all rights to (and related or associated with) any benefit claims and/or payments due from any third-party payor as reimbursement or payment for the Services, including but not limited to the rights to pursue administrative claims, request documents, receive payment and pursue litigation in order to obtain payment; (5) to the extent such assignment is unenforceable, designates Supplier to act as patient's "authorized representative" under 29 C.F.R. §2560.503-1(b)(4) and the Employee Retirement Income Security Act of 1974 (and any other applicable statutory or common law, rule or regulation), with respect to all aspects of patient's claim (the "Claim") for benefits under any applicable benefit or welfare plan for payment of the medical services rendered to patient by Supplier; directs patient's benefit or welfare plan and those who administer it, or those who communicate with participants and beneficiaries regarding claims for benefits, to communicate directly with Supplier regarding the Claim and payment of benefits relating to the Claim; and agrees that, as an integral part of pursuing the Claim (or an appeal of an adverse benefit determination) to its conclusion, Supplier shall receive any and all original information and notices, including without limitation checks or other forms of payment which are made to or on behalf of patient, or to which patient is entitled, with respect to the Claim (only copies may be sent to patient); (6) to the extent the assignment of benefits is enforceable, requests that payment of authorized Medicare, Medicaid, insurance or any other benefits be made on the patient's behalf directly to Supplier for the Services provided now or in the future, unless such request or direct payment would limit Supplier's ability to balance bill the patient or other responsible person; (7) agrees that the patient is financially responsible for, and obligated to pay, the amount charged by Supplier for the medical services, including any amount that is not paid by any third-party payor (unless Supplier is a contracted network provider for such payor, in which case any applicable co-pay or deductible is owed); (8) agrees to use his/her best efforts to cooperate with, and to assist, Supplier in receiving payment in full for the medical services rendered to patient, including immediately remitting to Supplier any payments received directly from an insurer or any source whatsoever for the medical services provided to the patient by Supplier; (9) agrees that Supplier is not liable for any personal items that are lost or damaged during patient transport; (10) agrees that the provisions of this agreement are severable and, to the extent that a provision is unenforceable, the balance of the agreement remains enforceable; and (11) agrees that a copy of this document is valid as an original for all purposes.

Supplier means _____

(Company name including any applicable d/b/a)

SECTION I - PATIENT SIGNATURE: Patient must sign here unless physically or mentally incapable of signing. If 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 Supplier (named above) 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. **Unless I am the legal guardian as indicated below, my signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- ☐ Minor patient's legal guardian
- ☐ 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 of Representative

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

In the event the patient expired, name of person/facility cancelling transport: _____

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 the receiving facility Face Sheet **and/or** the Patient Care Report (signed by a receiving facility representative) 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.