Sample Ambulance Signature/Claim Submission Authorization Form - Version 2.2CV

| ivacy Practices Acknowledgment: by signing below | | Transport Date: |
|--|--|--|
| | | viedges that [ABC Ambulance Service (ABC)] provided a copy of its Notice of Privacy to the patient. *A copy of this form is valid as an original* |
| 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. | | |
| future, until I revoke this authorization in writing. I use a regardless of my insurance coverage, and in some of immediately remit to [ABC] any payments that I recall rights to such payments to [ABC]. I authorize [AI holder of medical, insurance, billing or other relevance and Medicaid Services, and/or any other these or other benefits payable for any services pro | nderstand that I a cases, may be resteive directly from BCI to appeal pay int information ab payers or insurer vided to me by A | other payer for any services provided to me by [ABC] now, in the past, or in the am financially responsible for the services and supplies provided to me by [ABC] , sponsible for an amount in addition to what was paid by my insurance. I agree to m insurance or any source whatsoever for the services provided to me and I assign yment denials or other adverse decisions on my behalf. I authorize and direct any bout me to release such information to [ABC] and its billing agents, the Centers for rs, and their respective agents or contractors, as may be necessary to determine ABC, now, in the past, or in the future. I also authorize [ABC] to obtain medical, party, database or other source that maintains such information. |
| X | | For Known or Suspected COVID-19 Patient Only |
| Patient Signature or Mark | Date | ☐ CHECK HERE if patient gave verbal consent for ambulance crew to sign |
| X Witness Signature (only if Pt signs by mark) X | Date | Ambulance Crew Member Signature & Printed Name Date (Crew member should sign own name and not pt's name) |
| Witness Address (only if Pt signs by mark) | | |
| | | ED REPRESENTATIVE SIGNATURE tient is physically or mentally incapable of signing. |
| Describe the circumstances that make it impra | | |
| | e. By signing belo | a claim to Medicare, Medicaid, or any other payer for any services provided to the ow, I acknowledge that I am one of the authorized signers listed below. My e services rendered. |
| ☐ Representative of an agency or institution that | ecurity or other g patient's treatmen did not furnish th | governmental benefits on behalf of the patient nt or exercises other responsibility for the patient's affairs ne services for which payment is claimed (i.e., ambulance services) but furnished |
| □ Patient's legal guardian □ Relative or other person who receives social so □ Relative or other person who arranges for the person who are perso | ecurity or other g patient's treatme did not furnish th int | nt or exercises other responsibility for the patient's affairs the services for which payment is claimed (i.e., ambulance services) but furnished |
| □ Patient's legal guardian □ Relative or other person who receives social so □ Relative or other person who arranges for the person who are person who a | ecurity or other g patient's treatmen did not furnish th | nt or exercises other responsibility for the patient's affairs |
| Patient's legal guardian Relative or other person who receives social some Relative or other person who arranges for the Representative of an agency or institution that other care, services, or assistance to the patient X Representative Signature SECTION III - AMBUI Complete this section or (2) no authorized representative (Section or (Sec | ecurity or other gpatient's treatmend did not furnish the control of the control | Printed Name of Representative W AND RECEIVING FACILITY SIGNATURES ent was physically or mentally incapable of signing, and lable or willing to sign on behalf of the patient at the time of service. |
| Patient's legal guardian Relative or other person who receives social some Relative or other person who arranges for the Representative of an agency or institution that other care, services, or assistance to the patients X Representative Signature SECTION III - AMBUI Complete this section or (2) no authorized representative (Section or (S | ecurity or other gpatient's treatmend did not furnish the control of the control | Printed Name of Representative W AND RECEIVING FACILITY SIGNATURES ent was physically or mentally incapable of signing, and lable or willing to sign on behalf of the patient at the time of service. |
| Patient's legal guardian Relative or other person who receives social some Relative or other person who arranges for the Representative of an agency or institution that other care, services, or assistance to the patient X Representative Signature SECTION III - AMBUI Complete this section or (2) no authorized representative (Section of Complete the circumstances that make it imprantation of Receiving Facility: | Date LANCE CRE LLY if: (1) the patiction II) was available. | Printed Name of Representative W AND RECEIVING FACILITY SIGNATURES ent was physically or mentally incapable of signing, and lable or willing to sign on behalf of the patient at the time of service. |
| □ Patient's legal guardian □ Relative or other person who receives social some Relative or other person who arranges for the Representative of an agency or institution that other care, services, or assistance to the patient X Representative Signature | Date LANCE CRE LLY if: (1) the patient of the pati | Printed Name of Representative W AND RECEIVING FACILITY SIGNATURES ent was physically or mentally incapable of signing, and lable or willing to sign on behalf of the patient at the time of service. Time: — Time: — dedicaid, or any other payer for any services provided to the patient by [ABC]. Toy crew member at time of transport) attent was physically or mentally incapable of signing, and that none of the available or willing to sign on the patient's behalf. My signature is not an |
| □ Patient's legal guardian □ Relative or other person who receives social some Relative or other person who arranges for the Representative of an agency or institution that other care, services, or assistance to the patients X Representative Signature SECTION III - AMBUI Complete this section on (2) no authorized representative (Section of (2) no authorized representative (Section of (3) no authorized representative (Section of (4) no authorized representative (Section of (5) no authorized representative (Section of (6) no authorized representative (5) no authorized (6) no authorized (7) no authorized | Date LANCE CRE LLY if: (1) the patient of this form were | Printed Name of Representative W AND RECEIVING FACILITY SIGNATURES ent was physically or mentally incapable of signing, and lable or willing to sign on behalf of the patient at the time of service. Time: |
| □ Patient's legal guardian □ Relative or other person who receives social some Relative or other person who arranges for the Representative of an agency or institution that other care, services, or assistance to the patients of the patient of the patients of the patients of the patients of the patient of the patients | Date LANCE CRE LLY if: (1) the patient of the pati | Printed Name of Representative WAND RECEIVING FACILITY SIGNATURES ent was physically or mentally incapable of signing, and lable or willing to sign on behalf of the patient at the time of service. Time: Time: dedicaid, or any other payer for any services provided to the patient by [ABC]. Toy crew member at time of transport) attent was physically or mentally incapable of signing, and that none of the available or willing to sign on the patient's behalf. My signature is not an lered. |