Print

Version 2.2 – 10/21/2014

Callaway County Ambulance District – Patient Authorization

Patient Name: _____ **Transport Date:** _____

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Callaway County Ambulance District provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. **** A copy of this form is as 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.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other pay or for any services provided to me by Callaway County Ambulance District now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Callaway County Ambulance District, 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 Callaway County Ambulance District 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 Callaway County Ambulance District. I authorize Callaway County Ambulance District to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to Callaway County Ambulance District and its billing agents, the Centers for Medicare andMedicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Callaway County Ambulance District, now, in the past, or in the future. I also authorize Callaway County Ambulance District to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

If the patient signs with an "X" or other mark, a witness should sign below.

Witness Signature_____ Date_____

_____ _____

Patient Signature or Mark Date

Witness Address PO Box 246, Fulton, MO 65251

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 payer for any services provided to the patient by Call away County Ambulance District now or in the past, or in the future, where permitted. By signing below, I acknowledge that I am one of the following: (1) the patient's legal guardian; (2) a relative or other person who receives social security or other governmental benefits on the patient's behalf ; (3) a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; and/or (4) a 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 **My signature is not an acceptance of financial responsibility for the services rendered.**

Printed Name of Representative _____

_____ _____

Representative Signature Date Address of Representative_____

☐ Check this box if the representative signer is the patient's: (1) legal guardian, or (2) health care power of attorney

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 signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Callaway County Ambulance District.

A. **Ambulance Crew Member Statement (*must* be completed by crew member 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. **My signature is not an acceptance of financial responsibility for the services rendered.**

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

_____

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

_____ _____ _____

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.**

_____ _____ _____

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

Call Number: _____

Insurance Information

Medicare Number _____ Medicaid Number _____

Insurer or Medigap Insurer: _____

Policy/Group/ID No: _____

Insurance Address _____

_____

++

Patients under the age of 18 list Parent or Guardian:

Name: _____

Social Security #: _____-_____-_____

Mailing Address_____

_____

_____

Phone: _____

++

Complete the following section for any changes that need to be made to patient information currently in the system.

First Name: _____ Last Name: _____

Mailing Address: _____

_____

_____

Phone: _____

Social Security #:_____-_____-_____ Date of Birth: _____ Other:

_____

_____

_____