❑ C.J. Spellman Ambulance, Inc. ❑ Trans-Med Ambulance, Inc.

Patient Name: ______________________________ **Transport Date:** ______________

Service Incident#______________________**(Dispatch)** **Trip Sequence#**________________________

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to TRANS-MED AMBULANCE, INC. Ambulance for any services provided to me by TRANS-MED AMBULANCE, INC. now or in the future. I understand that, ***unless I am a Pennsylvania Medical Assistance Recipient,*** I am financially responsible for the services provided to me by TRANS-MED AMBULANCE, INC., 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 TRANS-MED AMBULANCE, INC. 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 TRANS-MED AMBULANCE, INC.. I authorize TRANS-MED AMBULANCE, INC. 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 TRANS-MED AMBULANCE, INC. 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 TRANS-MED AMBULANCE, INC., now or in the future. A copy of this form is as valid as an original.

For Pennsylvania Medical Assistance Recipients: My signature certifies that I received a service or item on the date listed below. I understand that payment will be made from Federal and State funds and that any false claims, statements, or documents, or concealment of material information may be prosecuted under applicable Federal and State Laws.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received Trans-Med Ambulance, Inc. 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.
Note: If the patient is a minor, the parent or legal Guardian should sign in this section.

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. This can be an ambulance crew member.

X________________________________
Witness Signature

____
Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section only if the 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 benefits on behalf of patient
- Relative or other person who arranges treatment or handles the patient's affairs
- Representative of an agency or institution that furnished 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 - AMBULANCE CREW AND FACILITY REPRESENTATIVE 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 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 to this patient.***

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 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 Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B above cannot be obtained)

If no facility representative signature is obtained, the ambulance crew should attempt to obtain 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)
- Facility Face Sheet/Admissions Record
- Patient Medical Record
- Hospital Log or Other Similar Facility Record