

COMMUNITY AMBULANCE SERVICES, INC.

Patient Name: _____

Date of Transport: _____

Destination Name: _____

I acknowledge that I am legally responsible for the ambulance services provided to me. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Community Ambulance Services, Inc. for any ambulance services and supplies furnished to me by Community Ambulance Services, Inc., whether in the past, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as Community Ambulance Services, Inc., any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now or in the future.

I acknowledge that I have been provided with a copy of Community Ambulance Services, Inc. Notice of Privacy Practices on this date.

Signature of Patient

Date

Reason Patient could not Sign: _____

REPRESENTATIVE SIGNATURE

By signing below, I certify that I am one of the following individuals, and that I authorized to sign on the patient's behalf (check one):

- Patient's legal guardian (42 C.F.R. §424.36(b) (1))
- Relative or other person who receives governmental benefits on the patient's behalf (42 C.F.R. §424.36(b)(2))
- Relative or other person who arranges patient's treatment or manages the patient's affairs (42 C.F.R. §424.36(b)(3))
- Representative of institution that furnished care or other services to the patient (42 C.F.R. §424.36(b)(4))

Signature of Representative

Printed Name of Representative

Date

FOR EMERGENCY TRANSPORTS ONLY

Complete this section only if you are unable to obtain the signature of the patient or authorized representative.

By signing below, I certify that the above-named patient was physically or mentally incapable of signing at the time of transport, and that none of the individuals listed in 42 C.F.R. §424.36(b)(1) – (4) was available or willing to sign the claim on behalf of the beneficiary

Crew Signature

Date

This section is to be completed by a representative of the receiving facility, whenever you are unable to obtain the signature of the patient or an authorized representative. **Note:** The crew must also complete the "Crew Signature" section above.

I certify that the above named patient was received by our facility on the date and time set forth above.

Signature of Receiving Facility Representative

Date

Printed Name of Receiving Facility Representative

Title

This Signature is not an acceptance of financial responsibility for the patient