EmergyCare and Corry Ambulance Assignment of Benefits & Privacy Acknowledgement Form

A copy of this form is as valid as an original

Run#	Unit#	Run Date	DOB
Last Name		First Name	Pt. SS#
Standby At:	Crew:		Trans. Agency:

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by EmergyCare and/or Corry Ambulance ("EC/CASI") now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by EC/CASI 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 EC/CASI 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 EC/CASI. I authorize EC/CASI 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 EC/CASI and its billing agents, the Centers for Medicare and Medicaid 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 EC/CASI, now, in the past, or in the future. **Privacy Practices Acknowledgement:** by signing below, I acknowledge that I have received EC/CASI's Notice of Privacy Practices.

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

X _____ Patient Signature or Mark _____ Date

X _____ 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 EC/CASI 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. **My signature is not an acceptance of financial responsibility for the services rendered.**

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

- ☐ Patient's legal guardian
- ☐ Relative or other person who receives social security or other government 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 the payment is claimed (i.e., ambulance services) but furnised other care, services, or assistance to the patient

X _____ Representative Signature _____ Date _____ Printed Name

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. 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: _____

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

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 facility to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

❑ Facility Log ❑ Facility Face Sheet/Admissions Record