NEMS, PCAS, FCEMS & MCEMS POB 2788 Tuscaloosa, Alabama 35403 Phn: 888-828-0911 Fax: 205-345-7911

THE INFORMATION ON TOP OF THIS FORM MUST BE COMPLETED ON EVERY CALL.

NAME: _____ DATE OF SERVICE: _____-_____-_____INCIDENT #: _____

SS# _____-____-_____ DOB: ____-____-____

***NEMS is Northstar EMS, Inc. PCAS is Pickens Co. Ambulance Service, FCEMS is Fayette Co. EMS, and MCEMS is Marion Co. in the following text.**

SIGNATURE and INSURANCE FORM

By signing below and/or accepting the services from *NEMS, PCAS, FCEMS, or MCEMS, constitutes an agreement of payment. In consideration for services rendered, the beneficiary agrees to reimburse *NEMS, PCAS, FCEMS, or MCEMS for all services including all applicable deductible, co-payment, and non-allowed charges, including such payments that remain unpaid after public or private insurance acknowledges the claim. Acknowledgement is made that *NEMS, PCAS, FCEMS, or MCEMS shall have cause, under the contract laws of the State of Alabama, to enforce the implied service contractual arrangement and payment may be recouped by property liens, small claims court proceedings, or other legal means. **Persons other than the beneficiary, spouse, or guardian of beneficiary are not responsible for payment.** Responsibility for payment is with the person receiving and accepting the services and/or their legal responsible parties. The signature agrees that all costs of collection will be added to the delinquent balance due. This includes cost of all collection fees, attorney fees, or court costs required in the process of collecting a delinquent account. The beneficiary hereby waives all rights to exemptions as to personal property stipulated under the Constitution of the State of Alabama. Failure to make a reasonable monthly payment may result in collection action.

LIFETIME AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *NEMS, PCAS, FCEMS, or MCEMS, Tuscaloosa, Alabama for any ambulance services and supplies furnished to me by *NEMS, PCAS, FCEMS, or MCEMS. I authorize any holder of medical information about me to release (by mail, fax, or e-mail) to CMS, it's agents and Carriers, Social Security Administration, all other third party payors as well as *NEMS, PCAS, FCEMS, or MCEMS, Tuscaloosa, Alabama and its billing agent (Capstone Claims), any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, in the **past, now and in the future unless specifically revoked in writing.**

I further appoint *NEMS, PCAS, FCEMS, or MCEMS to act as my representative, to present or elicit evidence (by mail, fax, or e-mail), to obtain appeals information, and receive any notice in connection with an appeal, wholly in my stead with any claims (past, present, and in the future) I have with *NEMS, PCAS, FCEMS, or MCEMS.

❑ **A notice of the HIPAA Privacy Practice was given directly to or left with the patient or their representative at the time of service.**

Signature by representative must be completed as: John Jones by Jane Jones. Name of the patient must appear on this page. Check why beneficiary could not sign. Representative must supply address below.

_____ ____-____-_____ Self Parent Spouse POA Other _____

Signature of Beneficiary or Representative (Reason must be stated if beneficiary does not sign) Date Signed Relationship of Signer to Beneficiary Circle One

_____

ADDRESS OF PATIENT OR PERSON SIGNING FOR BENEFICIARY IF NOT THE FACILITY REPRESENTATIVE

The signing of this form certifies that the beneficiary identified at the top of this form or on the signature line was transported to or from a medical facility by ambulance on the date of service noted above.

Reason Beneficiary could not sign: ❑TOO ILL WHY?_____ ❑MENTALLY IMPAIRED ❑MINOR (< 19, UNMARRIED, LIVING WITH PARENTS/GUARDIAN)

INITIAL HERE ❑ **NO PATIENT REPRESENTATIVE WAS AVAILABLE TO SIGN FOR THIS PATIENT AT THE TIME OF TRANSPORT. MUST BE DONE.**

TO BE COMPLETED BY THE FACILITY SIGNING AS THE PATIENT REPRESENTATIVE

Reason Beneficiary could not sign: ❑TOO ILL ❑MENTALLY IMPAIRED

(Please check the appropriate authorization under which you will be signing.)

- ❒ Patient's legal guardian
- ❒ Relative OR other person who receives governmental benefits on the patient's behalf.
- ❒ Relative OR other person who arranges patient's treatment or manages the patient's affairs.
- ❒ Representative of institution or facility that furnished care or other services to the patient.

Facility Representative Signature:_____ Date: _____/_____/_____

NAME AND ADDRESS OF FACILITY: _____

The signing of this form by a representative of the sending and/or receiving facility is in accordance with 42 CFR §424.36(b)(1)-(4) and does not create responsibility for payment. It only serves to confirm the transport of this patient on this date of service and authorizes us to file with CMS.

NO INSURANCE O **No insurance was indicated at time of service by this beneficiary. Should insurance become retroactively available, all authorizations contained on this form may be executed.**

MEDICARE # _____-_____-_____ ____ ❑ Primary ❑Secondary **MEDICAID #** _____ (13 DIGITS)

MEDICARE ADVANTAGE PLAN (MA) _____ **POLICY #** _____

IS PT UNDER HOSPICE? O**YES** O **NO** **AGENCY NAME:** _____

PRIVATE INSURANCE ❑ Primary ❑Secondary ❑Workers Comp Information Write down address and instructions from back of card on filing claims.

Carrier: _____ Policy Holder's Name: _____ DOB: ____/____/____

Contract #: _____ Group #: _____ Relationship of Patient to Policy Holder: **Self Spouse Child Other**

AUTOMOBILE INSURANCE (Signature constitutes agreement of lien on medical coverage) ❑ Unknown ❑ Patient states no auto insurance

Company: _____ Agent: _____ City & State _____