

Winchester Fire & Rescue
Ambulance Billing Authorization and Privacy Acknowledgment Form

Patient Name: _____ **Incident #:** _____ **Transport Date:** _____

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other insurance payer for any services provided to me by **Winchester Fire & Rescue (WFRD)** now, in the past, or in the future. I understand that I am financially responsible for the services provided to me by **WFRD**, 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 **WFRD** 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 **WFRD**. I authorize **WFRD** 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 **WFRD** and its billing agents, the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers 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 **WFRD** now, in the past, or in the future. A copy of this form is as valid as an original.

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that **WFRD** provided a copy of its Notice of Privacy Practices to the patient or other part with instructions to provide the Notice to patient.

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.

X _____
Patient Signature or Mark Date

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 Date

Witness Printed Name

Note: if the patient is a minor, the parent or legal guardian should sign in the section.

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if patient is physically or mentally incapable of signing.

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

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 to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided by **WFRD** now, in the past, or in the future. My signature is not an acceptance of financial responsibility for the services rendered.*

X _____
Representative Signature Date Printed Name of Representative

SECTION III - EMERGENCIES ONLY - AMBULANCE CREW AND FACILITY REPRESENTATIVE SIGNATURES

Complete this section **only** for emergency ambulance transport, if the patient was physically or mentally incapable of signing, and no authorized representative (Section II) was available or willing to sign on behalf of the patient at 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 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. This 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 III-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 signed 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 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