MONO COUNTY EMS

Patient Name: _____ **Transport Date:** _____

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Mono County EMS now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Mono County EMS, 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 Mono County EMS 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 Mono County EMS. I authorize Mono County EMS to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to Mono County EMS and its billing agents, the Centers for Medicare and Medicaid Services, 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 ABC, now, in the past, or in the future. I also authorize Mono County EMS to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

SIGNATURE SECTION:

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 this section.

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if 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

_____
Representative's Address

Please fill out the form below if you have insurance and return it immediately for your insurance company to be billed.

Primary Insurance

Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Policyholder ID's: _____ Social Security #: _____
Group Plan Number: _____
Policy Holder: _____ Relation: _____

Secondary Insurance

Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____
Policyholder ID's: _____ Social Security #: _____
Group Plan Number: _____
Policy Holder: _____ Relation: _____