Mount Laurel EMS Insurance Authorization Form

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

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Mount Laurel Township for any services provided to me by Mount Laurel EMS now or in the future. I understand that I am financially responsible for the services provided to me by Mount Laurel 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 Mount Laurel Township 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 Mount Laurel Township. I authorize Mount Laurel Township to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Mount Laurel Township and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Mount Laurel EMS, now or in the future. A copy of this form is as valid as an original.
Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received MLEMS Notice of Privacy Practices.

SIGNATURE SECTION:

ONE of the following three sections MUST be completed.

SECTION I – PATIENT SIGNATURE

This Section is for **emergencies or non-emergencies**. The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____
Patient Signature or Mark

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

_____
Witness Printed Name

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

This section is for **emergencies or non-emergencies**. 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.
☐ Rep. of provider or nonparticipating hospital (**only** if reasonable efforts were first made to obtain signature of one of the authorized signers listed above).

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

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

Complete this section **only** if **all** of the following are true: (1) the call is an **emergency** ambulance transport, (2) the pt was physically or mentally incapable of signing, **and** (3) no authorized representative (Section II) was available or willing to sign on behalf of the pt 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.

Reason pt incapable of signing: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____
Signature of Crewmember 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 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 hospital 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