9850 West 190th Street, Ste. B
Mokena, Illinois 60448
Suburban (708) 478-8880 • Chicago (773) 429-8880

MEDICARE BENEFICIARY SIGNATURE FORM

Patient Name: ______________________

Run Number: ______________________

Date of Transport: ______________________

Destination Name: ______________________

I acknowledge that I am legally responsible for the ambulance services provided to me. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to the above named ambulance service, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as the above named ambulance service, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, now or in the future until such time I revoke this authorization in writing.

I acknowledge that I have been provided with a copy of the above named ambulance service Notice of Privacy Practices on this date.

______________________ ______________________
Signature of Patient Date

By signing below, I certify that I am one of the following individuals, and that I am authorized to sign on the patient's behalf (check one):

- □ Patient's legal guardian (42 C.F.R. §424.36(b)(I))
- □ Relative or other person who receives governmental benefits on the patient's behalf(42 C.F.R. §424.36(b)(2))
- □ Relative or other person who arranges patient's treatment or manages the patient's affairs (42 C.F.R. §424.36(b)(3))
- □ Representative of institution that furnished care or other services to the patient (42 C.F.R. §424.36(b)(4))

______________________ ______________________ ______________________
Signature of Representative Printed Name of Representative Date

(Information below must be obtained if signature is not present above)

CREW SIGNATURE

Complete this section only if you are unable to obtain the signature of the patient.

Reason Patient could not Sign: ______________________

By signing below, I certify that the above-named patient was physically or mentally incapable of signing at the time of transport, and that none of the individuals in 42 C.F.R. §424.36(b)(1) -(4) was available or willing to sign the claim on behalf of the beneficiary.

______________________ ______________________ ______________________
Crew Signature Crew Signature Date

SIGNATURE OF REPRESENTATIVE OF INSTITUTION INVOLVED IN PATIENT CARE

This section is to be completed by a representative of the sending or receiving facility. Note: The crew must also complete the "Crew Signature" section above.

I am a representative of the institution named below. I certify that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another authorized representative, pursuant to 42 C.F.R. §424.36(b)(4), I hereby sign on the patient's behalf.

______________________ ______________________
Institution Name Date

______________________ ______________________ ______________________
Signature of Representative Printed Name of Representative Date

THIS SIGNATURE IS NOT AN ACCEPTANCE OF ANY FINANCIAL RESPONSIBILTY FOR THE PATIENT.