American Medical Response

Run Number: _____ Date & Time of Transport: _____

Patient Name: _____

Destination Name and Location: _____

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 AMR for any ambulance services and supplies furnished to me by AMR, whether in the past, 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 AMR, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now or in the future.

I acknowledge that I have been provided with a copy of AMR's Notice of Privacy Practices on this date.

_____ _____

Signature of Patient Date

Representative Signature

Reason patient could not Sign: _____

By signing below, I certify that I am one of the following individual 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)(1)
- ☐ 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(42C.F.R.§424.36(b)(3))

_____ _____ _____

Signature of Representative Printed Name Of Representative Date

Facility Signature

Complete this section only if you are unable to obtain the signature of the patient or authorized representative listed above

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 listed in 42 C.F.R. §424.36(b)(1)-(3) was available or willing to sign the claim on behalf of the beneficiary.

_____ _____

Crew Signature Date

This section is to be completed by a representative of the sending or receiving facility, whenever you are unable to obtain the signature of the patient or an authorized representative. Note: The Crew must also complete the "Crew signature" section above.

Name and Location of facility: _____

The above named patient, as described by AMR, was received by or transported from our facility, which provided care or assistance to the patient, on the date and time set forth above.

_____ _____

Signature of Receiving or Sending facility representative Date

_____ _____

Printed name if Receiving or Sending facility representative Title

AMR is required to obtain this form In order to summit a claim for payment to Medicare or other third party payer. This signature is not an acceptance of financial responsibility for the patient