Ambulance Billing Lifetime Authorization and Privacy Acknowledgment Form

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

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Coastal Health Systems of Brevard, Inc. (CHSB) for any services provided to me by CHSB now or in the future. I understand that I am financially and legally responsible for the services provided to me by CHSB, 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 CHSB 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 CHSB. I authorize CHSB 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 CHSB 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 CHSB, now or in the future. A copy of this form is as valid as an original.

Notice to Medicare/Medicaid Beneficiary

Medicare/Medicaid have rules and regulations requiring us to notify you when services to be provided may not be covered by Medicare/Medicaid.

Medicare/Medicaid only pay for services that they determine to be reasonable and necessary under section 1862 (a)(1) of the Medicare/Medicaid law. If Medicare or Medicaid determine that a particular service, although it would otherwise be covered is "not reasonable and medically necessary" under the Medicare/Medicaid program standards, Medicare/Medicaid will deny payment for that service.

Medicare will generally **deny payment** for the following services:

1. Ambulance transportation because your medical condition did not require an ambulance and you could have been transported by other means without endangering your health.
2. Ambulance transport for services that can be performed at the point of origin.
3. Ambulance transport to a physician's office.
4. Ambulance mileage beyond the closest facility able to treat your condition.

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received Coastal Health Systems of Brevard, Inc.'s Notice of Privacy Practices.

SIGNATURE SECTION:

One of the following two 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

If the patient signs with an "X" or other mark, it is recommended that someone sign below as a witness.

X _____
Witness Signature

_____
Witness Printed Name

If patient is physically or mentally incapable of signing, Section II must be completed.

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 (PUTS):

_____

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