AGREEMENT FOR PAYMENT OF TRANSPORTATION SERVICES

Date:

Patient:

Facility:

By your signature below, your facility has accepted responsibility for and agreed to be the payer for the named patient's transportation beginning _______________through _______________. If no ending date has been selected we will continue all requested transports for the patient until we have been notified by a time-stamped fax to discontinue transportation services. If the dates change (service requested before or after the included dates) from those listed herein Coastal Health Systems will still consider you as the payment guarantor unless otherwise advised by fax.

Services Request

❒ BLS Ambulance ❒ ALS Ambulance

❒ Special Handling charges due to this being a Bariatric Patient

The private pay payment rate information can be obtained from our billing department at (321) 633-7050 Extension 121.
Please have the appropriate authorized person sign and return this form by fax to (321)-633-8504, Attention: Billing. This form must be returned to the billing office by 2:00 P.M. the day before the scheduled transport. For transports on Saturday , Sunday and Monday we require the form to be in our office by 2:00 P.M. on Friday. If we do not receive the completed form within this time frame, your transport request will not be confirmed.

Signature of Facility/Guarantor: ____
Printed Name of the Facility/Guarantor: ______________________________________
Title of Facility Guarantor: ____

Revision Date 10/2010

486 Gus Hipp Boulevard
Rockledge, FL 32955
Visit us at: www.coastalhealth.org

Administration: *(321) 633-7050*
Communications: *(321) 631-1448*
Fax: *(321) 632-3005*

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