



BILLING AUTHORIZATION
Ambulance Transports to Destinations OTHER THAN FMH
(Where patient did not come to or from FMH)

Patient Name: _____ Transport Date: _____ Call#: _____

Address: _____

Destination (Facility Name and City): _____

ONE of the following three sections (I., II., or III.) must be completed

I. Authorization for Billing

I authorize NorthStar or Franklin Memorial Hospital as its billing agency to bill Social Security Administration and/or Centers for Medicare and Medicaid Services, any HMO/PPO, other private or public insurance, or their agents, fiscal intermediaries or carriers on my behalf for their services. I authorize the release to the Social Security Administration and/or Centers for Medicare and Medicaid Services, any HMO/PPO, other private or public insurance, or their agents, fiscal intermediaries or carriers or an independent agency performing billing or collection functions on behalf of the ambulance service, any personal, medical or billing information needed for this or a related claim. I understand I will be responsible for any services that are not paid/covered by my insurance. A copy of this authorization shall be valid as the original and shall remain in effect until revoked in writing by the patient/insured. I request payment of medical insurance benefits to the ambulance service and authorize them to appeal any denials or adverse decisions on my behalf.

Patient Signature: _____ Date: _____

II. If the patient is unable to sign due to a medical or physical condition (and an authorized representative is available to sign on behalf of the patient):

I am signing on behalf of the patient. Signing is not an acceptance of financial responsibility for the services rendered.

Authorized* Signature: _____ Date: _____

Printed Name: _____

**Authorized* representatives must be one of the following. Please check off relationship:

- 1. Patient's Legal Guardian
- 2. Patient's HealthCare Power of Attorney
- 3. Relative or other person who receives government benefits on behalf of the patient
- 4. Relative or other person who arranges treatment or handles the patient's affairs
- 5. Representative of an agency or institution that furnished care, services or assistance to the patient

III. If the patient is unable to sign due to a medical or physical condition AND no authorized person is available or willing to sign:

Crewmember

I attest that the patient is unable to sign due to a medical or physical condition and no authorized person is available or willing to sign for the patient.

Reason Patient Cannot Sign: _____

Crewmember Signature: _____ Date: _____ Time: _____

Crewmember Printed Name: _____

Receiving Facility:

The above named patient was received by this facility on _____ (Date) at _____ (Time)

Signature of Receiving Facility Representative: _____

Printed Name and Title of Receiving Facility Representative: _____