LIFETIME SIGNATURE AUTHORIZATION FORM (PAGE 1)

ABSOLUTE AMBULANCE BILLING
PO BOX 126 WVS
BINGHAMTON, NY 13905
(607) 723-4554
(800) 969-9722

Please complete the Authorization Form below by filling out any sections that apply to you, signing the form, and returning the form to use as soon as possible. Thank you!

Ambulance Service Used: _____

Date of Ambulance Service: _____

Assignment of Insurance Benefits

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, ambulance provider _____ or any insurance company, any information needed to determine Medicare benefits or the benefits payable for related services or any other type of insurance claim, now or in the future. I permit a copy of this authorization to be used in place of the original request that payment available under any insurance be made directly to ambulance provider _____.

Medicare Part B and/or Primary Insurance Waiver of Liability

Medicare and/or Primary Insurances will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. If Medicare and/or Primary Insurances determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under the Medicare program standards, Medicare and/or Primary Insurances will deny payment for that service. If Medicare and/or Primary Insurances denies payment, I agree to be personally responsible for payment.

Beneficiary Agreement: _____ (applicable only if checked)

I have been notified by the transporting agency that, in my case, Medicare and/or Primary Insurance is likely to deny payment for the services identified above, for the reason stated. If Medicare and/or Primary Insurance denies payment, I agree to be personally responsible for payment.

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I was provided with a copy of Notice of Privacy Practices by the transporting agency.

Signed _____ Date _____

Print Name _____

IF PATIENT UNABLE TO SIGN – RESPONSIBLE PARTY
PLEASE SIGN AND PRINT NAME AND RELATIONSHIP TO PATIENT.

LIFETIME SIGNATURE AUTHORIZATION FORM (PAGE 2)

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Patient Name: _____

Patient Street Address: _____

City, State, Zip Code: _____

Patient Telephone Number: _____

Patient Date of Birth: _____

Name and Address of Primary Insurance:

_____

_____

Primary Insurance Policy Number: _____

Name and Address of Secondary Insurance:

_____

_____

Secondary Insurance Policy Number: _____