

Ambulance Signature Requirement Form

Patient Name: _____ Run Number: _____

Destination Name: _____ Date of Transport: _____

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 Aetna Ambulance Service, Inc./Ambulance Service of Manchester, LLC/Metro Wheelchair Service, Inc. for any ambulance services and supplies furnished to me by Aetna Ambulance Service, Inc./Ambulance Service of Manchester, LLC/Metro Wheelchair Service, Inc., 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 Aetna Ambulance Service, Inc./Ambulance Service of Manchester LLC/Metro Wheelchair Service, Inc., 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 Aetna Ambulance Service, Inc./Ambulance Service of Manchester, LLC/Metro Wheelchair Service, Inc. Notice of Privacy Practices on this date.

Signature of Patient

Date

By signing below, I certify that I am one of the following individuals, and that I am authorized to sign on the patient's behalf (check one):

- Patient's legal guardian
- Relative or other person who receives governmental benefits on the patient's behalf
- Relative or other person who arranges patient's treatment or manages the patient's affairs

Signature of Representative

Date

SIGNATURE OF REPRESENTATIVE OF INSTITUTION INVOLVED IN PATIENT CARE

This section is to be completed by a representative of the sending or receiving facility. Note: the ambulance crew also completed a similar "Crew Signature" form related to this patient.

The following does NOT constitute acknowledgement of financial responsibility for services rendered to the patient.

I am a representative of the institution named above. I certify that our institution has furnished care or other services to the above named patient in the past. In the event that you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf.

Institution Name

Date

Signature of Representative

Date

Printed Name of Representative