

Clear Creek Ambulance Signature/Claim Submission Authorization Form

SECTION I: Assignment of Benefits/ Financial Agreement

The patient must sign here unless the patient is physically or mentally incapable of signing.

NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Clear Creek Ambulance now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Clear Creek Ambulance 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 Clear Creek Ambulance 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 Clear Creek Ambulance. I authorize Clear Creek Ambulance to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to Clear Creek Ambulance and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Clear Creek Ambulance, now, in the past, or in the future. I also authorize Clear Creek Ambulance to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

If the patient signs with an "X" or other mark, a witness should sign below.

X _____ X _____
Patient Signature or Mark Date Witness Signature Date

Witness Address

Patient Name: _____ Call #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact

Name of person not living with you: _____ Phone #: _____

Insurance Company: _____

Claims Address: _____ Policy #: _____

Group #: _____

Customer Service Phone #: _____

Supplemental Insurance: _____

Claims Address: _____ Policy #: _____

Group #: _____

Signature: _____ Date: _____

Relationship to patient: Self Parent Spouse Other: _____

Guarantor SSN: _____

SECTION II: Clear Creek Ambulance Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Clear Creek Ambulance's Notice of Privacy Practices on this date.

Date

Signature

Print Name of Patient

