

**AccuMed Billing, Inc.**  
**EMS Fee Change Authorization Form**

Please note: This form must be completed, dated and signed to authorize ANY fee changes.

**Customer Name:**

**Fee Change Effective Date:**

Service TYPE	RESIDENT Fee	NON-RESIDENT Fee
BLS Emergency		
BLS Non-Emergency		
ALS Emergency		
ALS Non-Emergency		
ALS 2		
Specialty Care		
Intercept		
Treat/No Transport		
Mileage		
Oxygen		
Standby		
Standby		
Wait time		
Wait time		
Other		
Other		

**Additional Instructions:**

--

Customer Signature:	
(Authorized Signature)	
Printed name:	

Date Form Received by AccuMed:	
Date Charges Entered into AccuMed Billing System:	
Date Copy Returned to Customer:	

**You may fax the form to 734-479-6319 or mail to AccuMed Billing, Inc., PO Box 2122, Riverview MI 48193-11322**