LIFETIME SIGNATURE AUTHORIZATION FORM

I request that payment of authorized Medicare or any insurance benefits be made either to me or on my behalf to ________________________________(name and address of ambulance company) for any ambulance services and supplies furnished to me by ______________________________(name of ambulance company). I authorize any holder of Medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) or any insurance carrier, their agents and carriers as well as ______________________________ (name and address of ambulance company), any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, now or in the future.

____________________________ ________________________________

Dated Signature of Beneficiary