

PROVIDER:		DISPATCH INFORMATION (circle one) EMERGENCY OR NON-EMERGENCY			RUN #
					D.O.S.
ODOMETER READINGS	EN ROUTE:	AT SCENE:		AT DESTINATION:	
PATIENT NAME		SS#	DATE OF BIRTH		LOADED MILES:
PATIENT ADDRESS		CITY	STATE	ZIP	PHONE
RESPONSIBLE PARTY NAME		RELATIONSHIP			PHONE ()
PATIENT INSURANCE INFORMATION					
MEDICARE NUMBER		BCBS CONTRACT NUMBER			GROUP #
MEDICAID RECIPIENT I.D.#					
COMMERCIAL INSURANCE NAME		ADDRESS			PHONE ()
POLICY HOLDER		CONTRACT/POLICY/I.D. NUMBER			GROUP #
COMMERCIAL INSURANCE NAME		ADDRESS			PHONE ()
POLICY HOLDER		CONTRACT/POLICY/I.D. NUMBER			GROUP #
AUTO INSURANCE		ADDRESS		CLAIM #	PHONE ()
WORKMEN'S COMPENSATION		ADDRESS		CLAIM #	PHONE ()
MEDICAL REASON PATIENT CANNOT BE TRANSPORTED BY ANY OTHER MEANS					
ALS Assessment?		Yes	No	DETAILED DESCRIPTION OF PATIENT'S MEDICAL CONDITION:	
Medically Necessary? Explain		Yes	No		
Needed to be restrained? Explain		Yes	No		
Unconscious / in shock? Explain		Yes	No		
Required oxygen or emergency treatment?		Yes	No		
Acute stroke or myocardial infarction?		Yes	No		
Visible hemorrhage? Explain		Yes	No		
Bed confined before time of transport?		Yes	No		
Bed confined after time of transport ?		Yes	No		
Patient moved by stretcher (explain purpose)?		Yes	No		
Other (EXPLAIN)					
LIFETIME PATIENT SIGNATURE AUTHORIZATION FORM & PRIVACY RIGHTS ACKNOWLEDGMENT					
<p>I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR ANY INSURANCE BENEFITS BE MADE TO ME OR ON MY BEHALF TO THE PROVIDER FOR ANY AMBULANCE SERVICES AND SUPPLIES FURNISHED TO ME BY PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION OR DOCUMENT ABOUT ME TO RELEASE TO ANY INSURANCE CARRIER, GOVERNMENTAL (CMS), OR THIRD PARTY AGENCY, AS WELL THE PROVIDER ANY INFORMATION OR DOCUMENTATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES OR ANY SERVICES PROVIDED TO ME NOW OR IN THE FUTURE.</p> <p>*IF THIS SERVICE IS NOT COVERED BY INSURANCE I ACKNOWLEDGE RESPONSIBILITY FOR THE BILL.</p> <p><i>*I ACKNOWLEDGE THAT I HAVE BEEN GIVEN A COPY OF MY PRIVACY RIGHTS (patient given copy of Rights YES or NO)</i></p>					
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: X				RELATIONSHIP TO PATIENT:	
EMS PERSONNEL SIGNATURE & CREDENTIALS REQUIRED X				PATIENT UNABLE TO SIGN DUE TO:	

Jun-04