AUTHORIZATION SIGNATURE FORM

Patient Name: _____ **Response 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 MedStar for any ambulance services and supplies furnished to me by MedStar, 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 be released 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 MedStar, 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 am aware MedStar is compliant with HIPAA regulations. A copy of our Notice of Privacy Practices is available on request, on our website www.MedStar911.org or contact MedStar via telephone (817) 923-3700.

Signature: X_____ **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 (42 C.F.R. §424.36(b) (1))

Relative or other person who receives governmental benefits on the patient's behalf (42 C.F.R. §424.36(b) (2))

Relative or other person who arranges patient's treatment or manages the patient's affairs (42 C.F.R. §424.36(b) (3))

_____	_____	_____
Signature of Representative	**Printed Name of Representative**	**Date**

MEDSTAR CREWMEMBER SIGNATURE

Complete this section only if you are unable to obtain the signature of the patient.

Reason Patient could not Sign: _____

By signing below, I certify that the above-named patient was physically or mentally incapable of signing at the time of transport, and that none of the individuals listed in 42 C.F.R. §424.36(b)(1) – (4) was available or willing to sign the claim on behalf of the beneficiary. Crew Signature: **X**_____ **Date:** _____

SIGNATURE OF REPRESENTATIVE OF INSTITUTION INVOLVED IN PATIENT CARE

I am a representative of the institution named below, which has or will furnish care to the above named patient. In the event that you are unable to obtain the patient's signature or the signature of an authorized Patient Representative, I hereby sign *in order to permit MedStar to submit a claim to Medicare for its services*.. **By signing this form I will not be held financially responsible for any care or other services provided. This signature is not an acceptance of financial responsibility for the patient.**

_____ **Date:** _____

Institution Name

X_____	_____	_____
Signature of Representative	**Printed Name of Representative**	**Title**