Ambulance Transportation Estimate

****Include a Face Sheet when faxing****

Patient Name: ____
LAST, FIRST MIDDLE

Date of Birth: ____/____/______ SSN: _____-____-______
(MM/DD/YYYY)

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

Requestor: ______________________ Title: _______________

Phone: _________________________ Fax: ________________

Origin: _________________________ Destination: _________________________

Address: _________________________ Address: _________________________

Unit & Room: _________________________ Unit & Room: _________________________

City, St, ZIP: _________________________ City, St, ZIP: _________________________

Date of Service: _________________________ Ph. Number: _________________________

Pickup Time: _____________ AM PM Round Trip? Yes No

MedStar Mobile Healthcare Estimated Cost: $_____________ (each way)
Please call the Communications Center @ (817) 927-9620 for an estimate.

The Estimated Cost is only an estimate and not a limit on the actual charges, which will be based on MedStar's current fee schedule for services rendered, supplies, and actual mileage per odometer readings.

The facility hereby agrees to be financially responsible for the actual cost of the non-emergency ambulance service described above and the signatory below represents that she/he is authorized to guarantee payment on behalf of the facility.

Facility to Be Billed: ____

Billing Address: ____

City, State, ZIP: ____

Phone Number: ____

______________________________ ______________________
Printed Name of Authorizing Representative Title

______________________________ ______/________/______
Signature of Authorizing Representative Date

[*Patient Sticker Here*]

Rev. 02/10/2020