Inv # _____ MR#_____

AIR CARE & MOBILE CARE
UNIVERSITY HOSPITAL, CINCINNATI

Patient Name: _____ **Run Number: _____**

Receiving Facility:_____ **Date of Transport:_____**

PATIENT SIGNATURE

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 University Hospital for any ambulance services and supplies furnished to me by Air Care & Mobile Care 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 release 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 University Hospital, Cincinnati, 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 have been provided with a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient Date

OR

PATIENT REPRESENTATIVE SIGNATURE

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))

Reason Patient Could Not Sign:_____

_____ _____ _____

Signature of Representative Printed Name of Representative Date

OR

CREW SIGNATURE

Complete this section <u>only</u> if you are unable to obtain the signature of the patient or authorized representative.

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) – (3) was available or willing to sign the claim on behalf of the beneficiary

_____ _____

Crew Signature Date

SIGNATURE OF REPRESENTATIVE OF FACILITY INVOLVED IN PATIENT CARE

This section is to be completed by a representative of the sending or receiving facility. Note: The crew must also complete the "Crew Signature" section above.

I am a representative of the facility named below. I certify that our facility has furnished care or other services to the above named patient. In the event you are unable to obtain the signature of the patient or another authorized representative, [pursuant to 42 C.F.R. §424.36(b)(4)], I hereby sign on the patient's behalf.

_____ _____

Facility Name Date

_____ _____

Signature of Facility Representative Printed Name of Facility Representative

This signature is not an acceptance of financial responsibility for the patient