

Incident #: _____



Patient Name: _____

Transport Date: _____

SECTION I - PATIENT SIGNATURE

Complete this section **only** if the patient is capable of signing

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by the Guam Fire Department now, in the past, or in the future, until such time as I revoke the authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by the Guam Fire Department, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to the Guam Fire Department any payments that I receive directly from insurance or any source whatsoever for the services provided to me, and I assign all rights to such payments to the Guam Fire Department. I authorize the Guam Fire Department to appeal payments, denials, or other adverse decisions on my behalf. I authorize and direct any holder of medical insurance, billing, or other relevant information about me to release such information to the Guam Fire Department and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors as may be necessary to determine these or other benefits payable for any services provided to me by the Guam Fire Department, now, in the past, or in the future. I also authorize the Guam Fire Department to obtain medical, insurance, billing, and other relevant information about me from any party, database, or other source that maintains such information.

If the patient signs with an "x" or any other mark, a witness should sign below.

Patient Signature or Mark Date Witness Signature Date

Witness Signature

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing

Describe the circumstances that make it impractical for the patient to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by the Guam Fire Department now, in the past, or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- Patient's legal guardian;
- Relative or other person who receives Social Security or other government benefits on behalf of the patient;
- Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs;
- Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

Printed Name & Signature of Authorized Representative Date

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if; (1) the patient is physically or mentally incapable of signing, **and** (2) No authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service

Describe the circumstance that makes it impractical for the patient to sign: _____

Name and Location of receiving facility: _____ Time: _____

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by the Guam Fire Department.

A. Ambulance crew member statement (must be completed by crew member at the time of transport)

My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature of Crew member Date Print Name and Title

Receiving Facility Representative Signature

The patient's name on this form was received by this facility on the date and at the time indicated, and this facility furnished care, services, or assistance for this patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature of Receiving Facility Representative Date Print Name and Title