LDCFM USE ONLY

Pt. Name:_____

_____

D.O.S _____

Call No. _____

Lawrence Douglas County Fire Medical
1911 Stewart Ave.
Lawrence, KS 66046
(785) 830-7040 FAX (785) 830-7090

Recently you were provided ambulance service from Lawrence Douglas County Fire Medical. We would like to file your insurance claim on your behalf. Please sign and return this form to us. Once we receive your authorization we will promptly process your insurance claim.

If you should have any questions, please contact our billing office at (785) 830-7040 or our Privacy Officer at (785) 830-7000.

AUTHORIZATION

By authorizing such treatment and/or transportation, I acknowledge I am responsible for paying Lawrence Douglas County Fire Medical for all charges based on Lawrence Douglas County Fire Medical current billing rates, regardless of whether or not I personally requested ambulance service originally. I hereby assign to Lawrence Douglas County Fire Medical all my rights and benefits for ambulance services by any and all my insurers and any third party agencies. I further authorize my insurers and any third party agencies to pay directly to Lawrence Douglas County Fire Medical whatever benefits or payments may be available for services rendered to me, or my dependents by Lawrence Douglas County Fire Medical. This also authorizes Lawrence Douglas County Fire Medical to appeal payment denials or other adverse decisions on my behalf without further authorization. I also acknowledge I am responsible for any charges deemed by my insurance company as not medically necessary. I further authorize the use or disclosure of my protected health information (PHI) for the purposes of treatment, payment and healthcare operations.

RELEASE

I hereby authorize release of any holders of any medical, hospital, or other records or information about me, or my dependents, to release to the Centers of Medicare and Medicaid Services (CMS), its intermediaries or other carriers, as well as Lawrence Douglas County Fire Medical, any such information needed to determine insurance and other third party benefits payable for any services provided to me or my dependents to Lawrence Douglas County Fire Medical or for related services now or in the future.

I acknowledge the receipt of the Notice of Privacy Practices of Lawrence Douglas County Fire Medical.

Patient's signature is required unless patient is physically or mentally incapable of signing. If unable to sign, an authorized representative signature is permissible.

_____ _____

Signature of Patient or Patient's Personal Representative Date

Personal Representative's Relationship/Capacity to Patient:_____

Printed Name of Personal Representative:_____

Printed address and telephone of Personal Representative:_____

_____

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