In order to file health insurance on your behalf, your signature is REQUIRED.

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to the EMS provider for any services provided to me now, in the past, or in the future. I understand that I am financially responsible for the services provided to me regardless of my insurance coverage and in some cases, may be for an amount in addition to that which was paid by my insurance. I agree to immediately remit 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 EMS provider. I authorize the EMS provider to appeal payment denials or other adverse decisions on my behalf without further authorizations. I authorize and direct any holder of medical information or documentation about me to release such information to the EMS provider, and its billing agents, and/or the Centers for Medicare & Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me now or in the future. A copy of this form is as valid as an original.

Please visit us online at www.emsmc.com/patient-portal/ to sign electronically.

Patient signature: Date:

Patient Representative: If the patient is unable to sign, please complete the section below. **If the reason the patient is unable to sign is not listed below, the patient will remain responsible for the full balance.** Please note, the Patient Representative is not financially liable for services rendered to the patient.

Unable to sign because (REQUIRED):

I am signing on behalf of the patient to authorize submission of the claim. By signing below, I acknowledge that I am one of the authorized signers listed below.

- ☐ Patient Legal Guardian
- ☐ Person receiving governmental benefits on behalf of patient
- ☐ Person who arranges for patient's treatment or exercises other responsibilities for their affairs
- ☐ Representative of a medical facility that provides other care, services or assistance to the patient

Representative Name Representative Signature

Contact Phone # Date

INSURANCE INFORMATION

TYPE: ☐ MEDICARE ☐ MEDICAID ☐ INSURANCE

NAME
NAME OF INSURED/GUARANTOR
POLICY HOLDER
POLICY HOLDER'S
SOCIAL SECURITY #
INSURANCE POLICY #
GROUP #

ANY ADDITIONAL INSURANCE

TYPE: ☐ MEDICARE ☐ MEDICAID ☐ INSURANCE

NAME
NAME OF INSURED/GUARANTOR
POLICY HOLDER
POLICY HOLDER'S
SOCIAL SECURITY #
INSURANCE POLICY #
GROUP #

THIRD PARTY LIABILITY INSURANCE

IF ACCIDENT RELATED, WHAT TYPE OF INSURANCE ARE YOU PROVIDING?

☐ WORKERS COMPENSATION ☐ AUTO ☐ OTHER INSURANCE

NAME OF INSURED/ POLICY HOLDER
CASE/CLAIM NUMBER #
EMPLOYER'S NAME AND ADDRESS
CLAIM MAILING ADDRESS

POLICY HOLDER'S DATE OF BIRTH
POLICY HOLDER'S EMPLOYER (IF APPLICABLE)
EMPLOYER'S TELEPHONE #
INSURANCE CO. TELEPHONE #

Need to make a payment?

Credit card or check (ACH) payments can be made at www.emsmc.com/patient-portal/ or by calling (800)814-5339. Payments made via our website will provide a confirmation number and option to receive the confirmation by email. Credit card payments returned by mail will not be processed.

There is a flat $5.00 convenience fee applied to each credit card transaction. To avoid this fee, please pay by check (online/mailed) or money order.