







Disclaimer: This page is provided for optional use by the ambulance provider; it is not required by the Minnesota EMS Regulatory Board.

Billing Information						
Medicare Number		Medicaid Number			Other	
Primary Insurance						
Company Name		Insurance Number			Group Number	
Insured Last Name <input type="checkbox"/> Same as Patient's		Insured First Name <input type="checkbox"/> Same as Patient's			M.I.	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian
Address <input type="checkbox"/> Same as Patient's		City	County	State	Zip Code	Home Phone
Secondary Insurance						
Secondary Insurance Company Name		Secondary Insurance Number			Group Number	
Insured Last Name <input type="checkbox"/> Same as Patient's		Insured First Name <input type="checkbox"/> Same as Patient's			M.I.	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian
Address <input type="checkbox"/> Same as Patient's		City	County	State	Zip Code	Home Phone
Type of Insurance						
<input type="checkbox"/> Private Insurance <input type="checkbox"/> Workers Comp <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> HMO/PPO <input type="checkbox"/> Contract Services						
Authorization For Billing						

I authorize the release to the Social Security Administration and Centers for Medicare and Medicaid Services, any HMO/PPO, other private or public insurance, or their agents, fiscal intermediaries or carriers or an independent agency performing billing or collection functions on behalf of the ambulance service, any personal, medical or billing information needed for this or a related claim. I understand I will be responsible for any services that are not paid/covered by my insurance. A copy of this authorization shall be valid as the original and shall remain in effect until revoked in writing by the patient/insured. I request payment of medical insurance benefits either to me or to the ambulance service.

Signature	Date
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**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I was provided with a copy of the ambulance services "Notice of Privacy Practices."

Signature	Date
Name Printed	Relationship To Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian

**Waiver of Liability**

I refuse treatment and/or transportation by the providing ambulance service. I assume responsibility for my own, my child's, or any family member's medical treatment. I have been advised to seek the attention of a physician. I release the providing ambulance service, its employees, officers and directors from liability resulting from my own, my child's, or any other family member's refusal of medical treatment or transportation.

Signature	Date
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**If Signing For A Minor**

Signature	Date
Name Printed	Relationship To Patient <input type="checkbox"/> Parent/Guardian

**Patient's Belongings**

Patient's Belongings	Location of Belongings	Who Belongings Were Left With
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