Indianola Fire Signature Form/Claim Submission Authorization Form – Version 2.2

Patient Name: _____ **Transport Date:** _____

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **INDIANOLA FIRE DEPT** now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **INDIANOLA FIRE DEPT**, 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. Our collection process consists of withholding state of Iowa income tax refunds or payments if payments on ambulance bills are not made. I agree to immediately remit to **INDIANOLA FIRE DEPT** 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 **INDIANOLA FIRE DEPT**. I authorize **INDIANOLA FIRE DEPT** to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **INDIANOLA FIRE DEPT** 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 **INDIANOLA FIRE DEPT**, now, in the past, or in the future. I also authorize **INDIANOLA FIRE DEPT** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that **Indianola Fire Dept.** provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. ***A copy of this form is valid as an original***

SIGNATURE SECTION:

ONE of the following two sections MUST be completed.

SECTION I – PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.

X _____ _____
Patient/Guardian Signature or Mark Date

If the patient signs with an "X" or other mark, someone should sign below as a witness. This can be an ambulance crew member.

X _____ _____
Witness Signature Date

_____
Witness Printed Name

NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE

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

Reason the patient is physically or mentally incapable of signing:

_____

Authorized representatives include **only** the following individuals (check one):

☐ Patient's Legal Guardian ☐ Patient's Health Care Power of Attorney
☐ Relative or other person who receives government benefits on behalf of patient
☐ Relative or other person who arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

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 **IFD** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed above. **My signature is not an acceptance of financial responsibility for the services rendered.**

X _____ _____ _____
Representative Signature Date Printed Name of Representative

PLEASE FILL OUT appropriate information: **Patient's Insurance information**:

***PRIMARY INSURANCE*:**

POLICY HOLDER NAME: _____DATE OF BIRTH: ___/____/___

NAME OF INSURANCE COMPANY: _____INS. CO. PH. NO. _____

PATIENTS POLICY/ID NO. / INS. NO.:_____GROUP NO.: _____

***SECONDARY INSURANCE*:**

POLICY HOLDER NAME: _____DATE OF BIRTH: ___/____/___

NAME OF INSURANCE COMPANY: _____ INS. CO. PH. NO. _____

PATIENTS POLICY/ID NO. / INS. NO.:_____ GROUP NO.: _____

PLEASE FILL OUT AUTO INFORMATION **ONLY** IF BILL IS TO BE SENT TO YOUR AUTO INSURANCE

AUTO INSURANCE :

POLICY HOLDER NAME: _____DATE OF BIRTH: ___/____/___

NAME OF INSURANCE COMPANY: _____ INS. CO. PH. NO. _____

ADDRESS:_____

PATIENTS POLICY/ID NO. / INS. NO.:_____CLAIM # _____