COMPANY NAME

DOE, JOHN	1A	SMITH, JIM
Attendant 1	Assigned Unit	Attendant 2

Office Use Only	
Run #	2
Invoice #	
Broker Trip #	

Patient Information

Patient	DOE, JOHNNY
Address	8 SUNVIEW ST — Room 101A
City, State Zip	LINCOLN, RI 02865
Phone	4014999478 — Other # 4013053755
Soc.Sec.No	012-34-5678 — County: County 1
Date of Birth	1/1/1969 — Hgt 6' — Wgt 195
Gender	Male — Nursing Home Admit Date
Marital Status	Married — Race WHITE
Allergies	THIS IS ALLERGY INFORMATION

Previous Address

Address	51 WASHBURN AVE
City, State Zip	EAST PROVIDENCE, RI 02916
Phone	401-435-2119

Insurance Information

		Policy
Insurance #1	INSURER 1	POL1
Insurance #2	INSURER 2	POL2
Insurance #3	INSURER 3	POL3
Bill To	Bill To 1	

	Primary/Guarantor	Secondary Contact	Alternate Contact
Name	JANE DOE	CONTACT NAME 2	RESP PARTY
Address	8 SUNVIEW ST LINCOLN, RI 02875	888 CONTACT 2 AVE LINCOLN, RI 02865	1 RESPON PARTY ST PAWTUCKET, RI 02861
Phone	401-2312-9478 X 2234	401-222-2221	333-333-3331
Mobile/Other	401-111-1112	401-222-2222	333-333-3332
Relationship	RELATIONSHIP 1	RELATIONSHIP 2	RELATION GUAR

Medical History THIS IS MEDICAL HISTORY INFORMATION. THIS IS MEDICAL HISTORY INFORMATION. THIS IS MEDICAL HISTORY INFORMATION. THIS IS MEDICAL HISTORY INFORMATION. THIS IS MEDICAL HISTORY INFORMATION. THIS IS MEDICAL HISTORY INFORMATION.

Reason for Transport	TRANSFER	(Other)	
Chief Compliant	DIAGNOSIS SAMPLE 1	Diag. Notes	SAMPLE DIAGNOSIS NOTES
Equipment	IV	Escort	RELATIVE
Precautions	FALL PRECAUTION	Level of Srv	AMBULATORY

# Stairs	TRANSPORT TO	TRANSPORT FROM
Facility Name	PROSO	PORINO'S
Doctor/Dept	Doctor 2 — Room/Apt 122A	Room/Apt
Address	8 SUNVIEW ST	85 WEBSTER STREET
City, State Zip	Lincoln RI 02865	PAWTUCKET RI 02861
Phone	401-305-3755	401-722-1111
Fax	888-698-7611	888-111-1111

All questions must be answered prior to turning in paperwork. Sample Message

#	Question	Y	N	#	Question	Y	N
1	Hospital Admit		✓	12	Medicare PCS Recvd'	✓	
2	Medically Necessary	✓		13	Medicaid Form 216 Recvd'		
3	Unconsious		✓	14	Broker Trip Order Recvd'		
4	Emergency		✓	15	Face Sheet Recvd'		
5	Restraints		✓	16	DNR		
6	Hemorrhaging		✓	17	Can Patient be Transported by other Means		
7	Bed Confined Before	✓		18	Can Patient Maintain Erect Sitting Position		
8	Bed Confined After			19	Foley Cath or Suprapubic Cath in Place		
9	Moved By Stretcher	✓		20	Adult Diaper in Place		
10	Inter-facility Transport	✓		21	Require Total Care w/ All Daily Activities		
11	Oxygen Required	✓		22	Vital Signs Noted		

This is a sample Crew Instruction

	Next Appt	Current Appt
Date	/ /	3/14/2009
Pickup Time		17:15
Appt Time		18:00
Procedure Time		18:10
Odometer From		
Odometer To		
Total Miles		

Attendant 1

Attendant 2

ACTUAL UNIT #

Printed: 3/14/2009 5:36:45 PM

Patient: Doe, Johnny Run # 2 Date of Transport: 3/14/2009

Destiniation: Proso Time of Destination: ____________

SECTION I – PATIENT SIGNATURE

I acknowledge that I am legally responsible for the ambulance services provided to me. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to COMPANY NAME for any ambulance services and supplies furnished to me by COMPANY NAME, whether in the past, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as COMPANY NAME, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now or in the future.

I acknowledge that I have been provided with a copy of COMPANY NAME Notice of Privacy Practices on this date.

X ______________________________ ____________

Signature of Patient Date

SECTION II – REPRESENTATIVE SIGNATURE

Reason Patient could not Sign (crew to complete): + ______________________________

I certify that the above named patient was received by our facility on the date and time set forth above. In the event you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf in order to permit COMPANY NAME to submit a claim to Medicare and/or any other third-party payers. MY SIGNATURE IS NOT AN ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR THE PATIENT.

______________________________ ______________________________ ____________

Signature of Representative Printed Name of Representative Date

SECTION III – RECEIVING FACILITY SIGNATURE

Complete this section ONLY if you are unable to obtain the signature of the patient or authorized representative.

By signing below, I certify that the above-named patient was physically or mentally incapable of signing at the time of transport, and that none of the individuals listed in 42 C.F.R. §424.36(b)(1) – (4) was available or willing to sign the claim on behalf of the beneficiary.

______________________________ ____________

Crew Signature Date

Reason Patient could not Sign (crew to complete): + ______________________________

I certify that the above named patient was received by our facility on the date and time set forth above. In the event you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf in order to permit COMPANY NAME to submit a claim to Medicare and/or any other third-party payers. MY SIGNATURE IS NOT AN ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR THE PATIENT.

______________________________ ____________

Signature of Receiving Facility Representative Date

______________________________ ______________________________

Printed Name of Receiving Facility Representative Title/ Position