

Area Metropolitan Ambulance Authority  
551 E. Berry Street  
Fort Worth TX 76110-4329  
(817) 927-9620 Communication Center  
(817) 927-9671 Fax



**Authorization for Release of Information  
Assignment of Benefits  
Medicaid Client Acknowledgement Statement  
Medicaid Private Pay Agreement**

**Patient Name:** \_\_\_\_\_ **Date of Service:** \_\_\_\_\_

I, the undersigned, authorize: (name of sending facility) \_\_\_\_\_ and (name of receiving facility) \_\_\_\_\_ to release copies of my entire medical record (including any drug and alcohol/mental health/communicable disease information, including HIV test results and AIDS related information, if any) to Area Metropolitan Ambulance Authority d.b.a. MedStar or its designated representative for the purpose of assigning MedStar with the collection of insurance benefits including, but not limited to, Medicare and/or Medicaid.

The undersigned does hereby assign to the Area Metropolitan Ambulance Authority d.b.a. MedStar (The Authority), the right to receive and or authorize any payment of any such insurance benefits to be made directly to me or on my behalf to the Authority for any ambulance services and supplies furnished to me by MedStar, now or in the future.

Payment and acceptance of insurance benefits does not release me from any unpaid portion of the bill, unless otherwise provided by law. I understand that I am financially responsible to the Authority for the regular charges for the services described herein and hereby guarantee payment of the bill for the same within 45 days of receipt. I agree to pay all collection costs, including reasonable attorney fees.

**MEDICAID BENEFICIARY - CLIENT ACKNOWLEDGEMENT STATEMENT**

"I understand that the services or items that I have requested to be provided to me on (Date of Service) \_\_\_\_\_ may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the HHSC or its health insuring agent determines the medical necessity of the services or items I request and receive. I also understand that I am responsible for payment of these services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

**MEDICAID BENEFICIARY - PRIVATE PAY AGREEMENT**

I understand the Area Metropolitan Ambulance Authority, d.b.a. MedStar is accepting me as a private pay patient for the period of this date of service(s), and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Is patient able to sign on their behalf? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, please detail the reason why. \_\_\_\_\_

Printed name of person signing on behalf of the patient: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*\* Refer to the back of this form for details \**

## **Patient Signature Requirements**

MedStar EMS requires the signature of the beneficiary, or that of his representative, for the purpose of submitting a claim to Medicare, Medicaid and/or Private Health Insurance. If the patient is unable to sign because of a mental or physical condition, a representative payee, relative, friend, representative of the institution providing care or a government agency providing assistance may sign on his behalf. A provider/supplier (or his employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

If the patient/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, Medicaid, and/or Private Health Insurance, but may bill the patient (or his estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the patient/representative decides to have Medicare, Medicaid, and/or Private Health Insurance pay for these items and services, then a patient/representative signature is required and the ambulance provider/supplier must afford the patient/representative this option within the claims-filing period.