Clear Form Print

Ambulance Transportation Estimate

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

****Include a Face Sheet when faxing****

Patient Name: _____
LAST, FIRST MIDDLE

Date of Birth: ____/____/_____ SSN: _____-____-_____
(MM/DD/YYYY)

Requestor: _____ Title: _____

Phone: _____ Fax: _____

Origin: _____ Destination: _____

Address: _____ Address: _____

Unit & Room: _____ Unit & Room: _____

City, St, ZIP: _____ City, St, ZIP: _____

Date of Service: _____ Ph. Number: _____

Pickup Time: _____ ☐ AM ☐ PM Round Trip? ☐ Yes ☐ No

MedStar Mobile Healthcare Estimated Cost: $_____ (each way)
Please call the Communications Center @ (817) 927-9620 for an estimate.

The Estimated Cost is only an estimate and not a limit on the actual charges, which will be based on MedStar's current fee schedule for services rendered, supplies, and actual mileage per odometer readings. Additional fees may be charged for wait times at a rate of $1.50 per minute. For a full fee schedule, please contact our Business Office at the above number during normal business hours. The law requires mileage be billed in accordance with odometer readings indicating the actual mileage traveled with the patient from origin to destination.

The facility hereby agrees to be financially responsible for the actual cost of the non-emergency ambulance service described above and the signatory below represents that she/he is authorized to guarantee on behalf of the facility.

Facility to Be Billed: _____

Billing Address: _____

City, State, ZIP: _____

Phone Number: _____

_____ _____
Printed Name of Authorizing Representative Title

_____ _____/_____/_____
Signature of Authorizing Representative Date

[*Patient Sticker Here*]

Rev. 02/25/2021