



Bangs Ambulance, Inc.
205 W Green St
Ithaca, NY 14850-5421
607-277-4911

**PLEASE READ CAREFULLY
ON BOTH SIDES!!!**

Please fill out the information below and return it by mail to us at the above address or fax it to 607-277-9281.

Insurance Information:

If you have insurance or you were involved in a motor vehicle accident, please provide us with the information so we can submit your claim on your behalf.

!!! PLEASE SEND A COPY OF YOUR INSURANCE CARD !!!

Primary Insurance Company: _____

Insurance Address: _____

Insurance Company Phone : _____ Policy/ID #: _____

Policy Holder's Name: _____ **Group #:** _____

Policy Holder's Address: _____

Policy Holder's Date of Birth: _____ **Policy Holder's Sex:** _____

Claim #: _____

Date of Transport: _____ Bangs Patient Account#: _____

 Secondary Insurance Company: _____

Insurance Address: _____

Insurance Company Phone : _____ Policy/ID #: _____

Policy Holder's Name: _____ Group #: _____

Policy Holder's Address: _____

Policy Holder's Date of Birth: _____ Claim #: _____

ATTENTION COLLEGE STUDENTS: If you have insurance through your college or university, that insurance will be your primary insurance. Schools automatically enroll students in the college or university insurance unless you signed a waiver opting out of their insurance.

SECONDARY INSURANCE: If a secondary insurance is to be billed, the patient needs to provide us with a copy of the primary insurance companies "Explanation of Benefits" (EOB) before we are allowed to bill the secondary insurance.



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Print Name: _____ Date of Service: _____

Signature Authorization Form

Section One - Authorization and Receipt of Notice of Privacy Practices

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Bangs** 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 provided to me by **Bangs**, 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. I agree to immediately remit to **Bangs** 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 Bangs. I authorize **Bangs** 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 **Bangs** 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 services provided to me by Bangs, now, in the past, or in the future. I also authorize Bangs to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that has such information.

By signing below I acknowledge that I have received the Bangs Ambulance Notice of Privacy Practices.

Patient Name _____

X _____ Date: _____

Section Two - Authorized Signer - complete ONLY if the patient is unable to sign

Authorized Signer Statement

An authorized signer 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 the patient
- Representative of an agency or institution that did not furnish the services for which payment is claimed (ie, ambulance services) but furnished other care, services, or assistance to the patient.

As an authorized signer I recognize that signing on behalf of the patient is not an acceptance of financial or any responsibility for service rendered. In my opinion the patient is physically or mentally incapable of signing for the following

reason: _____

Print Name _____ Signature _____ Date: _____

Relationship to the Patient _____