AMERICAN AMBULANCE

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STANDARD

SIGNATURE ON FILE FORM

Name of Patient: _____

Patient's HIC Number: _____

AASI Run Number: _____

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to American Ambulance Service, Inc. for any services furnished to me by American Ambulance Service, Inc. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, and its agent or other third party payors, any information needed to determine these benefits for services.

I permit the use of a copy of this authorization as an original.

I acknowledge that this authorization is valid now and in the future, unless I withdraw it in writing to American Ambulance Service, Inc.

Patient's Signature: _____

Date: _____

Authorized Signature *(If patient unable to sign)*: _____

Printed Name of Signer: _____

Relationship to Patient: _____

Reason patient unable to sign: _____

Date: _____