HOLLIDAYSBURG AMERICAN LEGION AMBULANCE SERVICE
801 Scotch Valley Road, PO Box 461, Hollidaysburg. PA 16648
814 - 695 - 1421

Patient Name: _____

Today's Date: _____/_____/_____ Incident Number: _____

RELEASE OF PATIENT INSURANCE INFORMATION

AND

ADVANCED NOTICE OF POSSIBLE INSURANCE DENIAL

Many insurance carriers, including Medicare will only pay for services determined to be reasonable and necessary under section 1862 (A) (a) of the Social Security Act. If your insurance carrier determines that a particular service is not reasonable and necessary under the insurance program standards, it may deny payment for that service.

INSURANCES/MEDICARE DO NOT USUALLY PAY FOR THIS SERVICE WHEN:

A patient could have been transported by other means, including a wheelchair van, stretcher van, or by private vehicle, even though no other transportation may be available.

A patient is transported to another hospital and the same services were available at the closest hospital.

BENEFICIARY AGREEMENT

Hollidaysburg American Legion Ambulance Service, Inc (HALAS) has notified me that my insurance company may deny payment for the items or services identified above, therefore if my insurance company denies payment. I agree to be fully responsible for payment of these services.

I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Service and its carriers and agents, as well as to HALAS Inc. and its billing agents and any other payers or insurers, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by HALAS, now or in the future. I permit a copy of this authorization to be used in place of the original, and request payment of authorized Medicare or other insurance benefits be made on my behalf to HALAS or any services provided to me by HALAS.

I also acknowledge that I have received a copy of the Hollidaysburg American Legion Ambulance Service Notice of Privacy Practices. A copy of this form is as valid as the original.

Signature of Patient _____ ☐ Patient Unable to Sign

Patient Representative's Signature _____

Relationship to Patient _____ Date_____

Print Name of Witness _____

Patient unable to sign because: _____