HOLLIDAYSBURG AMERICAN LEGION AMBULANCE SERVICE

PERSONAL CARE AND NURSING HOME RESIDENT INFORMATION FORM

Resident's Name _____

Date of Birth _____ Social Security # _____

Facility's Name _____ Telephone _____

Address _____

PLEASE COMPLETE BOTH PRIMARY AND SECONDARY INSURANCE

Medicare# _____ RR Medicare# _____Access# _____

Primary Insurance Co	Secondary Insurance Co
_____ Insurance Company	_____ Insurance Company
_____ Address	_____ Address
_____ City/State/Zip	_____ City/State/Zip
_____ Telephone #	_____ Telephone#
_____ Policy Holder	_____ Policy Holder
_____ Agreement/Group Number	_____ Agreement/Group Number

Responsible Party _____Telephone _____

Address _____

YOUR SIGNATURE IS REQUIRED

I authorize Hollidaysburg American Legion Ambulance Service (HALAS), to bill and receive payment from Medicare and/or other insurance carriers for any ambulance service I (we) may use. Services rendered that were not medically necessary will be subject to HALAS's current billing policy. I authorize any holder of medical information or documentation about me, to be released to Centers for Medicare & Medicaid Services, as well as HALAS, for the processing of any claim for services rendered. I permit a copy of this authorization to be used in place of the original.

I also acknowledge that I have received a copy of the Hollidaysburg American Legion Ambulance Service Notice of Privacy Practices.

Patient or Responsible Party's Signature Date

To all insurance carriers: Please make payment directly to Hollidaysburg American Legion Ambulance Service for services rendered.