Northern Oswego County Ambulance 21 Delano St Pulaski, NY 13142

Patients Name:_____ PRID:_____ DOS:_____

Assignment of Insurance Benefits

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by Northern Oswego County Ambulance now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Northern Oswego County Ambulance, 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 Northern Oswego County Ambulance and payments that I may receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Northern Oswego County Ambulance. I authorize Northern Oswego County Ambulance to appeal payments denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to Northern Oswego County Ambulance and its billing agents, the Centers for Medicare and Medicaid Services and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Northern Oswego County Ambulance now, in the past, or in the future. A copy of this form is valid as an original. ***Privacy Practices Acknowledgment:*** *by signing section 1, I acknowledge that I have received* ***Northern Oswego County Ambulance Notice of Privacy Practices.***

Automobile Accident/ No Fault (also covers pedestrians and bicyclist)

Insurance Carrier:_____ Policy Holder: _____ Claim Number:_____

Please select one of the following: ☐ *Driver* ☐ *Passenger* ☐ *Pedestrian*

EMS PROVIDER COMPLETE SECTION BELOW FOR ANY MVA (PRINT PATIENT NAME & DOB- EMS must sign & date the Provider Signature Line)

New York Motor Vehicle NO-Fault Insurance Law (Assignment of Benefits Form) (For Accidents occurring on and after 04/08/2014)

*I (patients name)_____ ("assignor") hereby assign Northern Oswego County Ambulance ("Assignee") all rights, privileges and remedies to payment for health care services provided by the assignee to which I am entitled under Article 51 (the No-Fault statue) of insurance law. The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for the services provided by said Assignee for injuries sustained due to the motor vehicle accident that occurred on (****print DOS****)_____, not withstanding any other agreement to the contrary. This agreement may be revoked when benefits are not payable based upon the Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the Assignor.* ***ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERICAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THIEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION. NYS form NF-AOB (Rev 01/2004) (Assignor signs section 1 below)***

Providers Signature: ***Date:***

SECTION 1- PATIENT SIGNATURE for release of all assignment of benefits listed above and privacy acknowledgement (to be Completed for all services). EMS will witness & date all signatures on their attestation form. *The patient must sign below unless the patient is physically or mentally incapable of signing (parents sign for minors).* ***When the patient I physically or mentally incapable of signing, Section 2 or 3 must be completed.***

Patient Signature (Assignor) Parent sign if Minor	***Date***	***Print Signer Name***

☐ ***Patient's Parent or Legal Guardian***

If the patient signs with an "X" or other mark, a witness should sign below

Witness Signature_____ Date_____ Print Name_____

Northern Oswego County Ambulance 21 Delano St Pulaski, NY 13142

Patients Name: _____ ***PRID:*** _____ ***DOS:*** _____

Signature Section : If section 1 is not completed, complete section 2 or 3

Section 2- Authorized Representative signature

Complete this section ONLY if patient is physically or mentally incapable of signing or a minor. This section must be completed by authorized representative.

The patient is physically or mentally incapable of signing because of the following reason(s):

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by Northern Oswego County Ambulance, now or in the past, (or in the future, where permitted). By signing below, I acknowledge that I am one of the authorized signers listed below. ***My signature is not an acceptance of financial responsibility for services rendered.***

Authorized representatives include ONLY the following individuals:

- ☐ *Patient's legal guardian*
- ☐ *Relative or other person who receives social security or other governmental benefits on behalf of the patient*
- ☐ *Relative or other person who arranges for the patient's treatment or exercise other responsibility for the patient's affairs*
- ☐ *Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e. ambulance services) but furnished other care, services, or assistance to the patient.*

Representative Signature *Date*

Printed name of representative *Representative's Address*

*State Relationship*_____

Section 3 – Ambulance Crew and Facility Representative Signatures

Complete this section ***ONLY*** *for emergency ambulance transports, if the patient was physically or mentally incapable of signing,* ***and*** *no authorized representative (as listed in section 2) was available or willing to sign on behalf of the patient at the time of service. Provider must complete section A along with B or C.*

A. ***Ambulance Crew Member Statement (must be completed by crew member at time of transport)***

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that no other authorized representative listed in section 2 of this form were available or willing to sign on the patient's behalf.

*Reason patient incapable of signing:*_____

*Name and Location of Receiving Facility:*_____ *Time at Receiving Facility:*_____

*X:*_____*Date:*_____ _____

Signature of Crewmember *Printed Name of Crewmember (MUST BE LEGIBLE)*

B. ***Receiving Facility Representative Signature***

The above named patient was received by this Facility at the date and time indicated above

*X:*_____*Date:*_____ _____

Signature of Receiving Facility Representative *Printed Name and Title of Receiving Facility Rep.*

C. *Secondary Documentation if no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more to the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by cs164.506 © of HIPAA.*

- ☐ ***Patient Care Report (signed by representative of receiving facility)***
- ☐ ***Facility Face Sheet/Admissions Record***
- ☐ ***Patient Medical Record***
- ☐ ***Hospital Log or Other Similar Facility Record***

Northern Oswego County Ambulance

21 Delano Street Pulaski, New York 13142
Telephone: (315) 298-6516 Fax: (315) 298-5598

Patient's Name:_____ PRID:_____ Date of Service:_____

Attestation Statement

I, _____ (print name of crew member), hereby attest that the patient care report accurately reflects signatures obtained and notations I made in my capacity as the treating (EMT-B, AEMT-I, AEMT-CC, AEMT-P)(circle one) when I treated and transported the above noted patient. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, and criminal liability.

Signature of Crew Member:_____ Date:_____

I, _____ (print name of crew member), hereby attest that the patient care report accurately reflects signatures obtained and notations I made in my capacity as the treating (EMT-B, AEMT-I, AEMT-CC, AEMT-P)(circle one) when I treated and transported the above noted patient. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, and criminal liability.

Signature of Crew Member:_____ Date:_____

****For ALS Assessment Attestation Only****

I, _____ (print ALS Crew Member Name), hereby attest that I performed in my capacity as a (AEMT-CC, AEMT-P) an Advanced Life Support (ALS) assessment on the above noted patient, and find no Advanced Life Support(ALS) interventions to be required or administered as a result of assessment findings, and therefore the patient was treated and transported in accordance to all applicable NYS Bureau of EMS Basic Life Support (BLS) Protocols.

Signature of ALS Provider:_____ Date:_____