Adair County Ambulance District
606 W Potter
Kirksville, MO 63501
660-665-0000

Patient Name: _____ **Account #** _____

*** THIS SECTION MUST BE SIGNED IN ORDER TO SUBMIT CLAIMS TO YOUR INSURANCE ***

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by Adair 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 Adair 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 Adair County Ambulance 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 Adair County Ambulance. I authorize Adair County Ambulance to appeal payment 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 Adair 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 Adair County Ambulance, now, in the past, or in the future.

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that Adair County Ambulance provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

X _____ X _____

Patient Signature or Mark Date Patient Representative/Witness Signature Date

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

Primary Insurance

☐ None ☐ Medicare ☐ Medicaid ☐ Private Insurance

Policy Holder's Name (if other than patient) | Patient's relationship to insured | Policy Holder's Date of Birth

Insurance Company Name | Insurance Company Phone Number

Insurance Company Address

Member Identification Number/Letters | Group Number

Secondary Insurance

☐ None ☐ Medicare ☐ Medicaid ☐ Private Insurance

Policy Holder's Name (if other than patient) | Patient's relationship to insured | Policy Holder's Date of Birth

Insurance Company Name | Insurance Company Phone Number

Insurance Company Address

Member Identification Number/Letters | Group Number

Accident/Injury Insurance

☐ None ☐ Liability ☐ Worker's Comp ☐ Private Insurance ☐ Auto

Policy Holder's Name (if other than patient) | Patient's relationship to insured | Policy Holder's Date of Birth

Insurance Company Name | Insurance Company Phone Number

Insurance Company Address

Member Identification Number/Letters | Group Number

In order to process your claim, please provide your insurance information above and mail the form to **Adair County Ambulance District, 606 W Potter, Kirksville, MO 63501** or fax it to **660-665-6311.**

A copy of this form is valid as an original