Noga Ambulance Service, Inc. NPI# 1376538793 Patient Encounter Form/Assignment of Benefits/Notice of Privacy Practices

SECTION I – PATIENT SIGNATURE

I acknowledge that I am legally financially responsible for all services provided to me, unless I am a Pennsylvania Medical Assistance Recipient. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to Noga Ambulance Service, Inc. for any transportation (i.e. ambulance and/or wheelchair van) service(s) furnished to me by Noga Ambulance Service, Inc., whether in the past, now, or in the future. I authorize any holder of medical information about me or other relevant documentation about me to be release to the Centers for Medicare and Medicaid Services, its agents, contractors, any and all appropriate third party payers, their respective agents and contractors, as well as Noga Ambulance Service, Inc., any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now, or in the future. **For Pennsylvania Medical Assistance Recipients:** My signature certifies that I received a service or item on the date listed on this form. I will consider this my Advanced Notice that this service possibly will **NOT** be a covered benefit, and that I will be responsible to pay. If the service is a covered benefit, I request payment of authorized benefits be made on my behalf to Noga Ambulance Service, Inc., whether in the past, now, or in the future. If services should be covered by the financial institution that I am currently enrolled in, I understand that payment will be made from Federal and State funds, any false claims, statements, documents, or concealment of material information may be prosecuted under applicable Federal and State laws. My signature certifies that I received a service or item on the date listed on this form. For all parties, I acknowledge that I have been informed of Noga Ambulance Service, Inc. Notice of Privacy Practices on this date. Additional copies can be located at www.nogaems.com or by calling Noga Ambulance Service, Inc. billing department at (724) 652-8300.

(Patient Signature) (Patient Print Name) **MANDATORY** (Date)

(Crew Signature) (Crew Print Name) **MANDATORY** (Date)

I attest above signature and/or mark is that of the patient listed on the transport report, as evidenced via crew (my) signature above.

Reason Patient Could Not Sign:

SECTION II – REPRESENTATIVE SIGNATURE - SENDING OR RECEIVING FACILITY - ROUTINE TRANSPORTS

By signing below, I certify that I am one of the following individuals, and that I am authorized to sign on the patient's behalf. I understand that I am signing in order to permit the above-named company to submit a claim for its services to Medicaid/Medicare and/or any other third-party payers. **My signature is not an acceptance of financial responsibility for the patient.**

MANDATORY –Box MUST be checked

- □ Patient's legal guardian (42 C.F.R. §424.36(b)(1))
- □ Relative or other person who receives governmental benefits on the patients behalf (42 C.F.R. §424.36(b)(2))
- □ Relative or other person who arranges patient's treatment or manages the patient's affairs (42 C.F.R. §424.36(b)(3))
- □ Representative of institution that furnished care or other services to the patient (42 C.F.R. §424.36(b)(4))

(Representative Signature) (Representative Print Name) **MANDATORY** (Date)

(Crew Signature) (Crew Print Name) **MANDATORY** (Date)

SECTION III – RECEIVING FACILITY SIGNATURE - BLS/ALS EMERGENCY TRANSPORTS ONLY

I certify that the below named patient was received by our facility on the date set forth above. In the event you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf in order to permit Noga Ambulance Service, Inc. to submit a claim to Medicaid/Medicare and/or any other third-party payers. **My signature is not an acceptance of financial responsibility for the patient.**

(Representative Signature) (Representative Print Name) **MANDATORY** (Title/Position) (Date)

(Crew Signature) (Crew Print Name) **MANDATORY** (Date)

Patient Name: _____ **DOB:** _____ **NAS Trip #:** _____

Destination: _____ **SS#:** _____ **Tx. Date:** _____

Revised: 04-15-2015