



Matanuska Susitna Borough  
 Ambulance Billing Dept  
 350 E Dahlia Ave  
 Palmer AK 99645

WWW.MATSUGOV.US

Phone (907) 861-8564  
 Toll Free 800 -770-2956  
 Fax (907) 745-9566

*As a courtesy, we will bill your insurance for you. Please provide a SIGNATURE in the appropriate section below AND complete the following information:*

YOUR PATIENT ACCOUNT NUMBER / NAME		PRIMARY INS COMPANY'S NAME	
PRIMARY INSURANCE COMPANY'S ADDRESS		TELEPHONE (     )	
CITY	STATE	ZIP	
POLICY HOLDER'S ID #		GROUP PLAN NUMBER	
YOUR SECONDARY INSURANCE COMPANY'S NAME			
SECONDARY INSURANCE COMPANY'S ADDRESS		TELEPHONE (     )	
CITY	STATE	ZIP	
POLICY HOLDER'S ID #		GROUP PLAN NUMBER	

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Matanuska ·Susitna Borough EMS ("MSB EMS") for any services provided to me by MSB EMS now, in the past or in the future. I understand that I am financially responsible for the services provided to me by MSB EMS, 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 MSB EMS 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 MSB EMS. I authorize MSB EMS to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to MSB EMS and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by MSB EMS now, in the past or in the future. A copy of this form is as valid as an original.

The section below is for Emergencies and Non-Emergency transports.

**SECTION I - PATIENT SIGNATURE**

Patient must sign here unless the patient is physically or mentally incapable of signing.

X \_\_\_\_\_ X \_\_\_\_\_  
 PATIENT SIGNATURE DATE

**SECTION II – AUTHORIZED REPRESENTATIVE SIGNATURE**

Complete this section only if patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable of signing: \_\_\_\_\_

Authorized representatives include only the following individuals (check one):

- PATIENTS LEGAL GUARDIAN  PATIENTS HEALTHCARE POWER OF ATTORNEY
- RELATIVE OR OTHER PERSON WHO RECEIVES GOVERNMENT BENEFITS OF BEHALF OF PATIENT
- RELATIVE OR OTHER PERSON WHO ARRANGES TREATMENT OF HANDLES THE PATIENT'S AFFAIRS

*I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.*

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
 Representative Signature Printed Name of Representative Relationship to Patient