

SouthBridge Emergency Medical Service  
 178 Hickory Grade Rd  
 Bridgeville, Pa 15017  
 412-221-5115

<b>Trip Number</b>
<b>Date of Trip</b>

WCV\_v1\_2011

**Wheelchair Van Service**

Patient Name	Date of Birth
Pick up location	Social Security #
Drop off location	
Admitting Diagnosis	

**Billing Information**

Responsible party		
Address		
City	State	Zip
Phone		
Contract Provider Information		
Paid with	<input type="checkbox"/> Check	<input type="checkbox"/> Credit card
		Amount \$
Card information/Name on card		
Card Number		
Expires	CVV2 code	

Base rate: \$72.50 (\$60.00 subscriber) each way. Oxygen: \$15.00 Mileage rate: \$3.00 per mile over ten miles

**Time and mileage**

Starting mileage	Enroute	Onscene
Ending mileage	Depart	Destination
Total miles	Available	Oxygen <input type="checkbox"/> check if SBEMS O2 used

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE, MEDICAID, OR ANY OTHER INSURANCE BENEFITS BE MADE ON MY BEHALF TO SB EMS FOR ANY SERVICES PROVIDED TO ME BY SB EMS NOW OR IN THE FUTURE. I AGREE TO IMMEDIATELY REMIT TO SB 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 SB EMS. I AUTHORIZE SB 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 SB EMS AND ITS BILLING AGENTS AND/OR THE CENTER 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 SBEMS, NOW OR IN THE FUTURE. A COPY OF THIS FORM IS AS VALID AS AN ORIGINAL.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE SERVICES PROVIDED BY SOUTHBRIDGE EMS (SB EMS). INSURANCE COMPANIES DO NOT PAY FOR WHEELCHAIR VAN SERVICE, EXCEPT WITH CERTAIN CONTRACTED PROVIDERS. I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICE. SB EMS IS NOT RESPONSIBLE FOR BILLING INSURANCE PROVIDERS EXCEPT WHEN PROVIDING PRE-AUTHORIZED CONTRACT BASED SERVICES. I ALSO ACKNOWLEDGE I HAVE BEEN GIVEN A COPY OF SB EMS'S PRIVACY POLICY.**

Signature X	Date
Crew Signature	Date