Patient Authorization | HIPAA Form

Completed form may be sent via Fax: 336.740.9773 or via e-mail: einfo@emsbilling.com

In order to submit all of the records that Medicare will require in the Appeals process, so they may reconsider payment of your claim, we have enclosed our patient authorization form to release the ambulance medical record to you. **Medicare cannot process your Appeal without this record.**

All highlighted areas must be completed in order to send the record to you. If you are not the patient, please send the court documents stating that you are the designated person that can obtain the record on behalf of the patient.

You may fax or mail the enclosed form back to us:

Fax: 336-740-9773
EMS Management & Consultants, Inc.,
PO Box 863, Lewisville, NC 27023

Please be advised that we cannot fax the records, it will be mailed to the address you have provided to us or if you are the designated person that can act on behalf of the patient, we will need your address along with court paperwork. We process patient authorizations daily and mail the record as soon as possible.

If you have any questions regarding this form, please contact our office at **800-814-5339**

Please follow the additional directions below to ensure that you will be sending the Medicare Appeals Officer all of the necessary records for their determination:

- Return our completed patient authorization form back to us so we may send the ambulance medical record to you. (DO NOT RETURN THIS INSTRUCTION LETTER WITH THE HIPAA FORM)
- Call Medicare to request the Appeal Form and the Medicare Denial.
- Call the hospital medical records department to request a copy of the Emergency Department record to show what transpired after arriving at the hospital.
- If you were picked up from a doctor's office or a facility, call them to request a copy of their record of events leading up to the ambulance transport.
- When you receive the Medicare Appeal Form, complete every area on the form. Provide as much detail as possible on the form so that the Appeals Officer can clearly understand all of the circumstances that occurred on the date of service.
- After you have received ALL of the requested records and you have completed the Medicare Appeal Form, make a copy for you to keep and submit the originals according to the instructions provided on the Appeal Form to Medicare.

Thank you

- **EMS|MC Patient Customer Service**

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PATIENT AUTHORIZATION
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form implements the requirements for patient authorization to use & disclose health information protected by the federal health privacy law, 45 CFR, parts 160, 164. Except as otherwise permitted or required by the privacy law, a health care provider subject to the privacy law may not use or disclose protected health information without an authorization that complies with the requirements of 45 CFR, 164.508(c).

Patient Name: _____ Date of Birth: ___/___/_____ Run # _____

Social Security Number (SSN): _____ Provider or Squad: _____

I hereby authorize EMS Management & Consultants, Inc. to use or disclose the following Protected Health Information:

_____ Ambulance Call Report and or Bill(s) _____

_____

This may be used or disclosed to: _____
Person or class of persons authorized to use or disclose the information

The purpose for the use or disclosure is: _____
_____

I understand that I have the following rights:

- To inspect and copy the information to be used or disclosed according to this authorization.
- To revoke this authorization at any time except for instances where EMS Management & Consultants, Inc. has already used or disclosed information subject to this authorization.
- To revoke this authorization, I must provide written notice to:

Privacy Officer
EMS Management & Consultants, Inc.
PO Box 863
Lewisville, NC 27023
336.766.4448 or 800.814.5339 Fax # 336.740.9773

Information used or disclosed according to this authorization may again be disclosed by the recipient. This information is no longer protected by privacy law.

Written authorization is not required for treatment, payment or healthcare operations.

I have read this authorization and I understand I have the right to refuse to sign it. I understand and agree to the terms of this authorization.

_____ _____
Patient Signature Date

_____ *(Circle if "Next of Kin" and patient is deceased)*
If personal representative, description of authority

_____
Expiration date or event