Your invoice number

EMS Medical Billing Associates, LLC

DATE:	04/07/2010
PATIENT:	FIELD, WILLIAM
INVOICE #:	10 - 10815
DATE OF SERVICE:	02/23/2010
SERVICE PROVIDER:	City of Green Bay Ambulance
PROVIDER ID #:	5002

WILLIAM FIELD
250 ELM ST
MILTON, WI 53563

Please furnish the following information and sign attached form(s) if you want us to deal with any third party.

PRIMARY HEALTH INSURANCE INFORMATION

(IF YOU HAVE NO INSURANCE, MARK "NONE")

NAME OF INSURANCE

GROUP NAME/EMPLOYER

POLICY# GROUP#

POLICY HOLDER D.O.B.

MAILING ADDRESS FOR CLAIMS

PHONE NUMBER FOR INSURANCE CO

OTHER HEALTH AND/OR AUTO INSURANCE

(IF YOU HAVE NO SECONDARY INSURANCE, MARK "NONE")

NAME OF INSURANCE

GROUP NAME/EMPLOYER

POLICY# GROUP #

POLICY HOLDER

MAILING ADDRESS FOR CLAIMS

PHONE NUMBER FOR INSURANCE CO

MOST CARRIERS HAVE FILING DEADLINES, SO PLEASE RETURN PROMPTLY

IF YOU HAVE ANY QUESTIONS, PLEASE CALL (866) 950-4400 THANK YOU

Please Fax or Mail Completed Form To:

EMS Medical Billing Associates, LLC • 9401 W Brown Deer Rd Ste 101
• Milwaukee, WI 53224-9004 • **Fax (414) 365-3889**

PATIENT NAME	DATE	INVOICE #
FIELD, WILLIAM	2/23/2010	10 - 10815

City of Green Bay Ambulance
100 N JEFFERSON ST
RM 106
GREEN BAY, WI 54301
Further Referred to as "Service Provider"

EMS Medical Billing Associates, LLC
9401 W Brown Deer Rd Suite 101
Milwaukee, WI 53224

Further Referred to as "Billing Agent"

I request that direct payment of all authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Servic e Provider for services provided to me by the Service Provider, now or in the future. I agree to remit to the Service Provider and its Billing Agent 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 the Service Provider. I authorize and direct any holder of medical information or documentation about me to re lease such information to the Service Provider and its Billing Agent, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as needed to determine these or other benefits payable for any services provided to me by the Service Provider, now or in the future. I understand that I am financially responsible for the services provided to me by Service Provider regardl ess of insurance coverage, and in some cases, I may be responsible for an amount in addition to that which was paid by my insura nce. I authorize the Service Provider and its Billing Agent to appeal payment denials or other adverse decisions on my behalf without further authorization. I also he reby acknowledge receipt of the Service Provider and Billing Agent's Notice of Privacy Practices.

SIGNATURE SECTION: *ONE* of the following two sections *MUST* be completed.

I – PATIENT SIGNATURE: The patient must sign here unless the patient is physically or mentally incapable of signing.

X_____
Patient Signature or Mark

If the patient signs with an "X" or other mark, it is recommended that someone sign as a witness. This can be an ambulance crew member.

X_____ _____
Witness Signature Witness Printed Name

II – AUTHORIZED REPRESENTATIVE SIGNATURE: Complete **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): ☐ Patient's Legal Guardian ☐ Patient's HCPOA
☐ Relative or other person who receives government benefit s on behalf of patient or arranges treatment or handles the patient's affairs
☐ Representative of an agency or institution that furnished care, services or assistance to the patient.

I am signing on behalf of the patient. Signing on behalf of the pa tient is not an acceptance of financial responsibility for the services rendered unless dictated so by a State or Federal law.

X_____ _____
Representative Signature Printed Name of Representative