SIGNATURE FORM/TRIP REPORT

Since you may be looking at changing your trip reports, ordering a new supply, having a separate signature form, etc., we have attached two forms for your consideration and implementation.

The two forms are different only with respect to the last section. Both forms are acceptable.

Sample Form #1 uses very "soft" language and is designed to meet the new exception for emergency that was created in the Final Rule, i.e. where the patient cannot sign and no authorized representative can sign for the patient, the receiving facility is allowed to sign acknowledging the patient was received by that hospital and when.

Sample Form #2 replaces the "Emergency" language and reason and is designed to cover the situation where the facility is signing on behalf of the patient, which we believe would therefore be good for emergencies and non-emergencies. We are waiting for confirmation from CMS on this point.

So, the difference in what the hospital is signing is that on Form #1 they are acknowledging they received the patient, which is enough for you to meet the new exception for emergencies; in Form #2, they are signing on behalf of the patient, in place of the patient signature, i.e. hopefully meeting the existing exception for when the patient is unable to sign, in the emergency as well as the non-emergency situation. Also, form #2, could be used for SNFs, not just by hospitals.

PCS FORM

For non-emergencies, we are suggesting you add language to your PCS form, so that a signature from someone at the facility can serve as a signature on behalf of the patient. The language we are suggesting is:

> "I certify that our institution has furnished care or other services to the above named patient in the past. In the event that you are unable to obtain the signature of the patient or another authorized representative, pursuant to 42 C.F.R. 424.36(b)(4), I hereby sign on the patient's behalf".

This is the same language added to form #2.

We are not attaching a suggested PCS form, as we do not want to superimpose a suggested form over one that is working for you. Therefore we simply suggest you add the language noted above. You may also want to print 42 CFR 424.36 (b)(4) on the back of your PCS form.

NOTE: If you are thinking about ordering trip reports due to this issue, please take into consideration:

- .while this is scheduled to be implemented 1/1/08, the A.A.A. will try to get implementation delayed.
- you can always use a stand-alone form, for now, for the signature.

SAMPLE SIGNATURE FORM #1

Patient Name: _____ Run Number: _____

Destination Name: _____ Date of Transport: _____

I acknowledge that I am legally responsible for the ambulance services provided to me. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to **[**name of ambulance service**]** for any ambulance services and supplies furnished to me by **[**name of ambulance service**]**, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as **[**name of ambulance service**]**, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, now or in the future.

I acknowledge that I have been provided with a copy of **[**name of ambulance service**]** Notice of Privacy Practices on this date.

_____ _____
Signature of Patient Date

By signing below, I certify that I am one of the following individuals, and that I authorized to sign on the patient's behalf (check one):

- ☐ Patient's legal guardian (42 C.F.R. §424.36(b)(1))
- ☐ Relative or other person who receives governmental benefits on the patient's 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))

_____ _____ _____
Signature of Representative Printed Name of Representative Date

CREW SIGNATURE

Complete this section only if you are unable to obtain the signature of the patient.

Reason Patient could not Sign: _____.

By signing below, I certify that the above-named patient was physically or mentally incapable of signing at the time of transport, and that none of the individuals listed in 42 C.F.R. §424.36(b)(1) – (4) was available or willing to sign the claim on behalf of the beneficiary

_____ _____
Crew Signature Date

FOR EMERGENCY TRANSPORTS ONLY

This section is to be completed by a representative of the receiving facility, whenever you are unable to obtain the signature of the patient or an authorized representative. **Note:** The crew must also complete the "Crew Signature" section above.

I certify that the above named patient was received by our facility on the date and time set forth above.

_____ _____
Signature of Receiving Facility Representative Date

_____ _____
Printed Name of Receiving Facility Representative Title

SAMPLE SIGNATURE FORM #2

Patient Name: _____ Run Number: _____

Destination Name: _____ Date of Transport: _____

I acknowledge that I am legally responsible for the ambulance services provided to me. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to **[**name of ambulance service**]** for any ambulance services and supplies furnished to me by **[**name of ambulance service**]**, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as **[**name of ambulance service**]**, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, now or in the future.

I acknowledge that I have been provided with a copy of **[**name of ambulance service**]** Notice of Privacy Practices on this date.

_____ _____
Signature of Patient Date

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 (check one):

- ☐ Patient's legal guardian (42 C.F.R. §424.36(b)(1))
- ☐ Relative or other person who receives governmental benefits on the patient's 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))

_____ _____ _____
Signature of Representative Printed Name of Representative Date

CREW SIGNATURE

Complete this section <u>only</u> if you are unable to obtain the signature of the patient.

Reason Patient could not Sign: _____.

By signing below, I certify that the above-named patient was physically or mentally incapable of signing at the time of transport, and that none of the individuals listed in 42 C.F.R. §424.36(b)(1) – (4) was available or willing to sign the claim on behalf of the beneficiary

_____ _____
Crew Signature Date

SIGNATURE OF REPRESENTATIVE OF INSTITUTION INVOLVED IN PATIENT CARE

This section is to be completed by a representative of the sending or receiving facility. Note: The crew must also complete the "Crew Signature" section above.

I am a representative of the institution named below. I certify that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another authorized representative, pursuant to 42 C.F.R. §424.36(b)(4), I hereby sign on the patient's behalf.

_____ _____
Institution Name Date

_____ _____ _____
Signature of Representative Printed Name of Representative Date