EMERGY CARE

PATIENT NAME _____ DATE OF SERVICE _____ RUN # _____

NOTICE OF EXCLUSION FROM INSURANCE* BENEFITS

There are items and services for which your insurance may not pay.

- Insurance does NOT pay for all of your health care costs. Insurance only pays for covered benefits. **Some items and services are not Insurance benefits and Insurance may not pay for them.**
- When you receive an item or service that is NOT an Insurance benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully**. Ask us to explain, if you don't understand why your insurance may not pay. Ask us how much these items or services will cost you. (**Estimated Cost: $** _____).

Insurance may not not pay for this ambulance transport:

☐ **1. Because it does not meet the definition of any Insurance benefit.**

☐ **2. Because of the following exclusion from Insurance benefits**:**

- ❑ Coverage excludes transports where other means of transport are not contraindicated
- ❑ Does not cover mileage beyond the closest appropriate facility
- ❑ Non-transporting advanced life support services are not covered
- ❑ Does not cover transports to certain excluded destinations (like doctor's offices)
- ❑ Will not pay for transports for the convenience of the family or the patient
- ❑ Will not pay for transports for the convenience of a specific physician
- ❑ Will not pay for wheelchair vans

☐ **3. Because no applicable insurance exists.**

***Medicare, Medicaid, Commercial Insurance, etc. hereinafter referred to as "Insurance"**
****This is only a general summary of exclusions from Insurance benefits. It is not a legal document. The official Insurance program provisions are contained in relevant laws, regulations, and rulings.**

Patient or Responsible Party Signature: _____

Print Name of Patient or Responsible Party: _____

Relationship: _____

Date: _____

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