CITY OF ________ FIRE RESCUE
PATIENT AUTHORIZATION FORM

Today's Date / / **Patient Number # __________________**
(Top right hand corner of bill)

Name of Patient: ____

Mailing Address: ____

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Home Phone: __________________ **Patient Date of Birth: / /**

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Check Appropriate Box:

☐ **MEDICARE# ________________________**

☐ **MAINECARE (formally MEDICAID) # ________________________**

☐ **OTHER INSURANCE**
Company Name ____

Address: ____

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Policy or ID # ____

Group Name & # (if applicable) ____________________________

Policy Holders Name ______________________________________

Policy Holders DOB / /

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I request that payment of authorized Medicare benefits or other insurance's may be made on my behalf to the City of ________ Fire Rescue for any service furnished to me by them. I authorize the holder of medical information about me to release to the Health Care Financing Administration or other insurance agencies any information needed to determine the benefits payable for related services. I agree to make sure I have completed all paperwork required by my insurance company in a timely fashion so that they may release payment to the provider, City of ________ Fire-Rescue. If I fail to complete said requirements I understand that I may be responsible to pay for services rendered.

☐ **I acknowledge that I have received a copy of the City of _____ Fire Rescue Department Notice of Privacy Practices. A copy of this form is as valid as the original**

Patient/Authorized Signature _____ Date / /
Patient Unable to Sign Because: _____
Rescue Member Signature _____ Lic # _____

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