

**Town of Colonie Claim Submission Authorization Form**

**Patient Name:** \_\_\_\_\_ **Transport Date:** \_\_\_\_\_

**Privacy Practices Acknowledgment:** by signing below, the signer acknowledges that **Town of Colonie EMS Dept.** provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. **\*A copy of this form is valid as an original\***

**SECTION I - PATIENT SIGNATURE**

The patient must sign here unless the patient is physically or mentally incapable of signing.  
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Town of Colonie EMS Dept.** now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **Town of Colonie EMS Dept.**, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to **Town of Colonie EMS Dept.** 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 **Town of Colonie EMS Dept.** I authorize **Town of Colonie EMS Dept.** to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **Town of Colonie EMS Dept.** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **Town of Colonie EMS Dept.** now, in the past, or in the future. I also authorize **Town of Colonie EMS Dept.** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

*If the patient signs with an "X" or other mark, a witness should sign below.*

X \_\_\_\_\_ X \_\_\_\_\_  
Patient Signature or Mark Date Witness Signature Date  
\_\_\_\_\_  
Witness Address

**SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE**

Complete this section **only** if the patient is physically or mentally incapable of signing.

**Describe the circumstances that make it impractical for the patient to sign:** \_\_\_\_\_

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Town of Colonie EMS Dept.** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- Patient's legal guardian
- Relative or other person who receives social security or other governmental benefits on behalf of the patient
- Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X \_\_\_\_\_  
Representative Signature Date Printed Name of Representative

You can mail, fax or email the completed form to  
the Colonie EMS Department at:

Fax: 518-782-2656 or  
email it to [ems@colonie.org](mailto:ems@colonie.org)  
312 Wolf Rd  
Latham NY 12110