EMS Notice of Non-Coverage

Patient Name:______________________ DOB:______________________

Account # : ______________________ Service Date:______________________

Insurance Type:______________________ Insurance ID:______________________

NOTE: Medical information currently available shows the ambulance transfer you are to receive may not be covered by your insurance.
If insurance doesn't pay for the service below, you will be responsible for payment.

Service(s) Insurance May Not Pay:	Reason Insurance May Not Pay:	Estimated Cost
Ambulance Transport and Mileage	Insurance does not cover services that are not medically necessary	☐BLS Service $______ ☐ALS Service $______ Also $ ______ per Mile

Your signature below acknowledges your understanding of insurance non-coverage and agreement to pay for this service.

______________________ ______________________
Patient Signature Date

____
If Representitive, List Relationship to Patient

______________________ ______________________
Witness Signature Date

Advanced Beneficiary Notice