Chapin Ambulance
22 Tyler Street, Springfield MA 01109
Phone: (413) 209-8830
Fax: (413) 342-4556

AUTHORIZATION TO BILL FACILITY FOR NON-EMERGENT & EMERGENT MEDICAL TRANSPORTATION

Facility Name: _________________________ MassHealth Pending? Yes No (Circle One)

Patient Name: _________________________ Patient DOB:_____________________

Date of Authorized Trip:__________________ # of Authorized Trips:______________

Mode of Transportation Requested (Circle One): ALS Ambulance BLS Ambulance Wheelchair Van

I am an authorized representative of the above facility. I understand the regulations and guidelines as set forth by the Centers for Medicare & Medicaid Services (CMS) in Chapter 10 Section 3.3 for Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service. Specifically, I understand the following:

> *Transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip, is covered under Part B provided that the ambulance transportation was medically reasonable and necessary and all other coverage requirements are met.*
>
> *Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service.*

Additionally, I understand that regulations and guidelines as set forth by MassHealth in 130 CMR 406.411 Transportation Utilization Requested in regards transportation services. Specifically, I understand the following:

> *The MassHealth agency pays for transportation services that meet the requirements of 130 CMR 407.000 only when such services are covered under the member's MassHealth coverage type and only when members are traveling to obtain medical services covered under the member's coverage type.*
>
> *In the case of fee-for-service ambulance and wheelchair van transportation, it is the responsibility of the transportation provider to judge which medical services are covered by MassHealth and to advise the member in cases where transportation is requested to a service that, in the provider's judgement, may not be or is not covered by MassHealth.*

While, under CMS and MassHealth guidelines, the above transport(s) are the financial responsibility of the patient, I hereby authorize that the above facility will be held financially responsible for the indicated non-emergent, or emergent, medical transportation of this patient. If "YES" is circled above for MassHealth Pending, I understand that the facility will be billed only after MassHealth adjudicates the patient's case, or six months after the date of service, whichever is sooner. Further, I authorize Chapin Ambulance LLC to invoice the facility for payment. I understand that payment for this service must be received within 30 days of the invoice date, unless otherwise indicated per the facility contract.

Signed Name_______________________________ Title_______________________________

Printed Name_______________________________ Date_______________________________

In Order To Be Valid, This Form MUST be Signed By An Administrator or Other Authorized Representative of The Above Facility