



CITY OF POMPANO BEACH EMS
PO BOX 1280
OAKS PA 19456-1280
ADDRESS SERVICE REQUESTED

EXDIGP04

THIS IS NOT A BILL
Additional Information Needed to
Submit Insurance Claim

Approved 5/14/2021

«NCOAControl» «IMBSerialNumber»

Mail this completed form to:

«FULLNAME»
«ADDRESS1»
«ADDRESS2»
«CITY» «STATE» «ZIPCODE»-«ZIPPLUS4»

POMPANO BEACH
PO BOX 978597
DALLAS, TX 75397-8597

CONFIRMATION #: «INSERT3»
ACCOUNT #: «INSERT1»
DATE OF SERVICE: «Insert2»

DATE: May 14, 2021

On the date of service listed above, ambulance transport services were provided to you by City of Pompano Beach EMS. We currently have no insurance information on file for you. We are requesting this information so that we can properly bill your insurance company for these services. Your response is critical to ensure accurate and timely billing and payment. It is easy to provide the information using any of the methods below:

By Phone: 888-204-7219
By Mail: Mail this completed form to:
Pompano Beach, PO BOX 978597, DALLAS, TX 75397-8597
By Fax: Fax a copy of your insurance card along with this letter to 833-689-5804
Online: At [HTTPS://PBFR.PAYAMBULANCE.COM](https://PBFR.PAYAMBULANCE.COM)

INSURANCE INFORMATION

TYPE: MEDICARE MEDICAID INSURANCE

NAME: _____

NAME OF INSURED: _____

POLICY HOLDER: _____

POLICY HOLDER'S SSN: _____

INSURANCE POLICY #: _____

GROUP #: _____

ANY ADDITIONAL INSURANCE

TYPE: MEDICARE MEDICAID INSURANCE

NAME: _____

NAME OF INSURED: _____

POLICY HOLDER: _____

POLICY HOLDER'S SSN: _____

INSURANCE POLICY #: _____

GROUP #: _____

THIRD PARTY LIABILITY INSURANCE

IF ACCIDENT RELATED, WHAT TYPE OF INSURANCE ARE YOU PROVIDING?

TYPE: WORKER'S COMPENSATION AUTO OTHER INSURANCE

NAME OF INSURED: _____

CASE/CLAIM #: _____

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

CLAIM MAILING ADDRESS: _____

POLICY HOLDER'S DATE OF BIRTH: _____

POLICY HOLDER'S EMPLOYER: _____

EMPLOYER'S TELEPHONE #: _____

INSURANCE CO. TELEPHONE #: _____

PATIENT /AUTHORIZED REPRESENTATIVE 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 this section.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to me by City of Pompano Beach EMS now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by City of Pompano Beach EMS, 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 City of Pompano Beach EMS, 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 City of Pompano Beach EMS. I authorize City of Pompano Beach EMS to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to City of Pompano Beach EMS 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 City of Pompano Beach EMS now, in the past, or in the future.

Please check one of the following to identify signature below:

- ☐ Patient
- ☐ 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 exercise 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

Patient or Representative Signature: _____ Date: _____

If someone other than the patient signed above, please explain the circumstances that make it impractical for the patient to sign:



CITY OF POMPAÑO BEACH EMS
PO BOX 1280
OAKS PA 19456-1280
ADDRESS SERVICE REQUESTED

EXDIGP04

«FULLNAME»
«ADDRESS1»
«ADDRESS2»
«CITY» «STATE» «ZIPCODE»-«ZIPPLUS4»

May 14, 2021

Dear «FullName»,

The reverse side contains the City of Pompano Beach EMS Notice of Privacy Practices & Legal Rights.

City of Pompano Beach EMS

Notice of Privacy Practices & Legal Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice:

We are required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how we are permitted to use and disclose PHI about you. We are also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI:

We will not use or disclose your PHI for any purpose other than treatment, payment, and healthcare operations unless you have signed a form authorizing the use or disclosure with the exceptions of the situations outlined below. Authorization is also required for sale of PHI, disclosures of psychotherapy notes, marketing uses and disclosures when you receive payment from a third party. Examples of our use of PHI:

For Treatment

This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other healthcare personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch centers well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For Payment

This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For Healthcare Operations

This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use & Disclosure of PHI Without Your Authorization

We are permitted to use PHI without your written authorization, or opportunity to object in certain situations, including: For our use in treating you or in obtaining payment for services provided to you or in other healthcare operations and for the treatment activities of another healthcare provider;

To another healthcare provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company), or to another healthcare provider (such as the hospital to which you are transported) for the healthcare operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;

To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called 911 or help for you.

In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our EMS crew; To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law;

For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system. For healthcare fraud and abuse detection or for activities related to compliance with the law; For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;

For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;

For military, national defense and security and other special government functions; To avert a serious threat to the health and safety of a person or the public at large;

For workers' compensation purposes, and in compliance with workers' compensation laws;

To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law; If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;

For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Access to Your Protected Health Information

As a patient, you have a right to receive a paper or electronic and/or inspect much of the PHI we retain on your behalf, unless excluded by law. All requests for access must be submitted on a HIPAA compliant records release form and signed by you or your legal representative, or a subpoena. We may charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

The Right to Amend Your PHI

You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of

your request and will notify you when we have amended the record. We are permitted by law to deny your request to amend your medical information only in certain circumstances like when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact the privacy officer listed at the end of this Notice.

The Right to Request an Accounting of Our Use & Disclosure of PHI

You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization on. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

The Right to Request That We Restrict the Uses & Disclosures of Your PHI

You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. You have the right to pay out of pocket in full and request that we not disclose your PHI to a health plan for payment or healthcare operations purposes. We are required to comply with your request for this type of restriction. But if you request a restriction of your health information and this information is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a healthcare provider to afford you with emergency treatment. We are not required to agree to any restrictions you request, but any restrictions agreed to by us are binding. **Right to Obtain Copy of Notice**
You may obtain a copy of this Notice through the privacy officer listed below.

Breach Notification

In the event of a Breach of Unsecured PHI, we shall comply with the HIPAA/HITECH breach notification requirements, which will include notification and actions we took to minimize the impact that breach may or could have had on you and/or your family member(s).

Revisions to the Notice

We reserve the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints

You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Comments or complaints may be directed to the privacy officer listed at the end of this Notice. Individuals will not be retaliated against for filing a complaint.

To request access to your PHI, if you have any questions, or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Privacy Officer, City of Pompano Beach EMS 954-786-4510
120 S.W. 3rd Street Pompano Beach, FL 33060