NON-MEMBERS

ADVANCED BENEFICIARY NOTICE – NOTICE TO INSURANCE BENEFICIARY

PATIENT NAME: ______________________________ D.O.S.: ______________

Medicaid & other insurance carrier rules and regulations require us to notify you when services that are to be provided are not covered. When your carrier determines that a particular service is non-covered or not necessary under the Insurer program standards, they will deny payment for the service. Your insurance carrier will deny payment for the following service(s) to be provided to you by Mutual Aid Ambulance Service, Inc.:

Ambulance/Medical Transportation

For the following reasons: (Check applicable lines)

- ☐ Insurer does not cover ambulance transport to a hospital for the services, which could be provided at residence/ECF.
- ☐ Insurer does not cover ambulance transport to doctor's office.
- ☐ Insurer does not cover ambulance transport for patient's convenience.
- ☐ Insurer does not cover ambulance transport to the destination facility.
- ☐ Insurer does not cover transport for patients in an ambulette, wheelchair, medivan, or car.
- ☐ Insurer does not cover services without a transportation component.
- ☐ Insurer does not cover services that are not medically necessary
- ☐ Beneficiaries MA benefit group does not cover ambulance transportation of this type

Therefore, we are requires to give you this notice advising you that your insurance carrier does not cover the charges for the services rendered, and you will be responsible for payment.

ALS Transport Rate--:$725 ________
BLS Transport Rate:--$600 ________
Mileage Rate Per Loaded Mile:
________ X $12 = ________

Total Quoted: ________

WheelChair Van Rate--$60 ________
Mileage Rate Per Loaded Mile:
________ X $3 = ________

Total Quoted: ________

I have been notified by ______________________________ that, in my case, my insurance carrier does not cover the services identified above, for the reason stated. Since the services being rendered are considered non-compensable or non-reimbursable by the guidelines set forth by the Centers for Medicare and Medicaid Services, the Office of Medical Assistance of Pennsylvania or other insurance carriers, I agree to be personally and fully responsible for payment to Mutual Aid Ambulance Service, Inc.

Patient Signature: ______________________________ Date: ______________

Printed Patient Name: ______________________________

Created on 01/24/2012
This for is created by the Ambulance Association of penna. Reimbursement Committee in accordance with applicable rules, regulation, and