GATES VOLUNTEER AMBULANCE SERVICE, INC.

1001 ELMGROVE ROAD • ROCHESTER, NY 14624-1362
PHONE: (585) 247-5519, Option 2 • FAX: (585) 426-5948
EMAIL: PATIENTBILLING@GATESEMS.ORG

To provide/update insurance information, complete the form below and return via mail or email. Thank you!

Patient Information

Name:		
Date Of Birth:		**SSN:**
Address:		
City:	**State:**	**Zip Code:**
Phone #:		

Please indicate if applicable:
☐Auto Accident
☐Worker's Compensation

Primary Insurance Information	Secondary Insurance Information
Carrier Name:	**Carrier Name:**
Member ID:	**Member ID:**
Carrier Address:	**Carrier Address:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Policyholder's Name:	**Policyholder's Name:**
Policyholder's Date of Birth:	**Policyholder's Date of Birth:**
Policyholder's ID Number	**Policyholder's ID Number**
Group ID:	**Group ID:**

Privacy Practices Acknowledgment: By signing below, the signer acknowledges that **Gates Volunteer Ambulance Service, Inc. (GVAS)** 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

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by GVAS now, in the past, or in the future, until I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by GVAS, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to what was paid by my insurance. I agree to immediately remit to GVAS 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 GVAS. I authorize GVAS 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 GVAS 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 GVAS, now, in the past, or in the future. I also authorize GVAS to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

New York No-Fault Motor Vehicle Insurance Law Assignment of Insurance Benefits:

In consideration for services rendered or to be rendered to the above-named patient, I hereby authorize payment directly to the above-named hospital, physician or other provider or health care services of any and all first party no-fault automobile insurance benefits to which I may otherwise be entitled for services rendered by the provider, but not to exceed the provider's charges for such services. In the event the provider's charges are outstanding and I fail to file an application for benefits under the New York State No-Fault Insurance Law, I hereby authorize the provider to file such claim on my behalf so that the provider may realize payment for charges. I understand that, if the provider does not receive payment from the insurer, I am personally responsible for the payment of the provider's charges.

X_____ _____ _____

Signature of Patient/Legal Guardian/Next of Kin **Relationship to Patient/Self** **Date**