Wheelchair Transports

Person Requesting Transport: _____ Request Date: _____

Patient's Name: _____ Room # _____

Pick Up Date __/__/__ Pick Up Time ____:____ Appointment Time ____:____

Pick Up Location: _____ Phone#: _____-_____

Take To Location: _____ Phone#: _____-_____

1. Will a caretaker accompany the patient? ___Yes ___No
2. Is the patient going in a Geriatric Chair? ___Yes ___No
3. Does the patient require special equipment of monitoring? ___ Yes ___No
   If yes, please explain: _____

*** Wheelchair van services are not covered by Medicare, Medicaid, or insurance Companies. This service will be provided @ $50.00 per trip with a charge of $3.00 per mile outside of the county and will be billed accordingly. The requesting facility and/or patient will be financially responsible for charges incurred from these services.**

I understand that I am financially responsible for the services provided to me by Harnett County Emergency Medical System regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Harnett County Emergency Medical System for any services provided to me by Harnett County Emergency Medical System. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to Harnett County Emergency Medical System and its billing agents and any other payers or insurers, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Harnett County Emergency Medical System, now or in the future. I agree to immediately remit to Harnett County Emergency Medical System any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to Harnett County Emergency Medical System.

I also acknowledge that I have read and/or received a copy of the Harnett County Emergency Medical System HIPAA Notice of Privacy Practices. A copy of this form is as valid as the original.

Patient Mailing Address: _____

_____

Patient Date of Birth: _____

_____ Date: _____
Patient Signature

_____ _____
Patient Representative's Signature Relationship to Patient

Patient unable to sign due to: _____

After completion, fax to Harnett County EMS at 910-814-2570. If you have questions, please call 910-893-7563 for assistance.

Revised 3-25-14