

# AUTHORIZATION TO BILL

**Municipality of Anchorage**  
**c/o Medical Support Services**  
**610 South Bailey Street**  
**Palmer, AK 99645**  
**Toll free number: 877-488-4146**

Patient Name:	
Patient Date of Birth:	
Date of Transport:	
Phone Number:	

*I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Anchorage Area Wide Emergency Medical Services (AAWEMS) for any services provided to me by AAWEMS now or in the future. I understand that I am financially responsible for the services provided to me by AAWEMS, 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 AAWEMS or its billing agent 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 AAWEMS. I authorize AAWEMS or its billing agent to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to AAWEMS and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by AAWEMS, now, in the past, or in the future. A copy of this form is as valid as an original.*

**Signature of Patient/ Authorized Agent** \_\_\_\_\_ **Date** \_\_\_\_\_  
 Authorized Agent – please signify relationship:     Parent/Legal Guardian     POA     Spouse     Other \_\_\_\_\_

<b>Medicaid or Denali Kid Care Number</b>	
<b>Medicare Number</b>	

**Primary Insurance Information**

Name of Insurance Carrier			
Address of Insurance Carrier			
Phone Number of Insurance Carrier			
Policy Holder's Full Name		Policy Holder DOB	
Policy/ID or SS Number <i>(List the number that is on your insurance card)</i>		Group #	
Policy Holder's Employer			

**Secondary Insurance Information**

Name of Insurance Carrier			
Address of Insurance Carrier			
Phone Number of Insurance Carrier			
Policy Holder's Full Name		Policy Holder DOB	
Policy/ID or SS Number <i>(List the number that is on your insurance card)</i>		Group #	
Policy Holder's Employer			

**QUESTIONS AND BILLING INQUIRES PLEASE CALL (877) 488-4146 OR (907) 745-4146**