McLaren
MEDICAL GROUP

AMBULANCE TRANSFER
FINANCIAL RESPONSIBILITY

Date of Service: _____

Under recommendation of your provider, you have agreed to be transferred from

_____ to _____ by ambulance.

(Name of Center) (Name of Receiving Facility)

Please be aware that your insurance policy may or ***may not*** cover this service.

If this service is ***not*** a covered benefit, you will be financially responsible for all charges related to your ambulance transfer.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

If patient is a minor or patient is unable to consent, please complete the following:

Patient is unable to consent due to _____

_____

_____

_____

___.

Signature of Legal Guardian/Closest Available Relative _____ Date _____

Signature of Witness _____ Date _____

Patient Name:

Date of Birth:

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