MEDICAL CLAIM AID
400 Market Street, Denton, MD 21629
Office:410-479-4790, or toll free 800-432-5940
Fax:410-479-4793, or toll free 800-764-6420
angela@medicalclaimaid.com

To Whom It May Concern:

It is the policy of the Ocean City Fire Department – Career Fire/EMS Division not to release any patient information and/or medical records unless Care Report Release has been completed by the patient or legal representative. This policy ensures that the patient's rights and confidentiality are kept in accordance with current guidelines proposed by the health care industry. **OCFD does not do billing, all request for billing information must go to Medical Claim Aid**

MEDICAL CLAIM AID
Ocean City Fire Department: EMS AMBULANCE TRANSPORT BILLING REQUEST FORM

Patient's Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Social Security No.:_____ Date of Service:_____

Patient Rights: As a patient, you have the right to access, copy or inspect your billing information as a result of an OCFD Ambulance Transport.

Release to be made: To patient only over the age of 18. Patients under the age of 18 release must be completed by parent or legal guardian

To Law Firm or Legal Representation (with proper documentation)
To spouse, child (over age 18), or Legal representation of deceased patient

I authorize Medical Claim Aid to release my OCFD Ambulance Transport billing records for the purpose(s) specified above.

Name of person making request:_____ Request date:_____

Signature:_____ Relationship to Patient:_____

Parent/ Legal Guardian Name:_____

MUST INCLUDE COPY OF ID (ID information must match)

Return completed waiver via fax or to email above with copy of ID
I authorize Medical Claim Aid to release and E-mail my records (unless signed records will be mailed or faxed)

Signature:_____ Email Address:_____

Please mail report to the following address (if different than the address shown above):

_____

Upon receipt of the Release Waiver, we will forward a copy of the report as instructed. Should there be any questions and/or comments, please contact Medical Claim Aid at the address shown above.

Processed by:_____ Date:_____