Billing Guideline Agreement

PARAMEDIC BILLING SERVICES INC

Contract Start Date:_____

LEGAL ORGANIZATION NAME: _____

The client identifies as a:

- ☐ Fire Dept/Municipality
- ☐ Fire Protection District
- ☐ Other?

If Fire Dept/Municipality, is the client:

- ☐ Home Rule
- ☐ Non-Home Rule

Headquarters Address: _____

County: _____

Phone: _____

Fax: _____

Additional Municipal Building or Practice Locations: _____

_____

CONTACTS		
Provide Name/Title below:	**Identify primary billing contact**	**Provide email below**
Fire Chief:		
Deputy Chief:		
EMS Coordinator:		
Admin Support:		
Accounting/Financial Manager: (who pays invoice)		
ADMIN USER FOR INSURANCE SITES. Information is necessary to provide for transition of all payment authorizations from previous billing agency to PBS.		
Provide Name/Title below:	**Identify primary billing contact**	**Provide email below**
Change Healthcare:		
Payspan:		
Forward Health:		
Optum Pay:		

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IMPORTANT IDENTIFICATION NUMBERS / AUTHORIZED OFFICIAL:	
Tax Identification Number:	
National Provider Identification Number:	
Medicare Provider Number:	
Medicare/PECOS Authorized Official & Email:	
Main & Satellite Fire Stations Address for PECOS Registration-Validation:	
1.)	
2.)	
3.)	
4.)	
5.)	
Public Aid Provider Number:	
Blue Cross/Blue Shield Provider Number:	
Railroad Medicare Provider Number:	
US Department of Labor OWCP Provider ID Number:	
Other State Medicaid Provider Numbers, if any: (i.e. California, Iowa, Missouri, Minnesota etc.):	
CAQH Provider Data Login Portal access (a.k.a. CAQH ProView):	
Previous Banking Information with OLD Agency	Name of Bank:_____ ACH Account #:_____ ACH Routing #:_____
Wintrust Lockbox Bank Authorized Contact	Contact Name: _____ Phone #: _____ Email: _____
Current Banking Information - If PBS owes Client money, please provide where to route EFT payments below:	Name of Banking Institution:_____ ACH Account #: _____ ACH Routing #:_____

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EMS System Name:	
Medical Director Name:	
List all hospital locations department transports to:	
1.)	6.)
2.)	7.)
3.)	8.)
4.)	9.)
5.)	10.)

Software & PCR Transmission process:

Software in use

- ☐ ImageTrend
- ☐ ZOLL
- ☐ ESO
- ☐ EMSCharts
- ☐ Other: _____

How will PCR's be sent to Paramedic Billing Services

☐ FTP(PDF)		☐ FTP(Export)	
If Exporting, who owns the license?	☐ PBS	☐ CLIENT	☐ Other: _____

Resident Billing Procedures:

1.) Choose only one:

- ☐ The department **DOES** bill residents. (Proceed to #2)
- ☐ The department does **NOT** bill residents. (Proceed to Non-Resident Billing Procedures)

2.) Resident billing procedure, PBS should:

- ☐ For residents, accept insurance payment as payment in full. Any or all remaining charges are written-off. (If checked, proceed to Non-Resident Billing Procedures)
- ☐ Balance bill residents, after insurance pays for:

Choose all that apply:

- ☐ Any remaining balance. (All or partial)
- ☐ Insurance assigned patient deductible.
- ☐ Insurance assigned patient copay/coins.

Choose only one:

- ☐ If resident balance (All or partial) is not paid, balance will **NOT** be sent to external collections.
- ☐ If resident balance (All or partial) is not paid, balance **WILL** be sent to external

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Non-Resident Billing Procedures:
Choose only one:
If there is a remaining balance (All or partial) for Non-Residents, PBS should:
☐ Bill to collect from the patient, but **DO NOT** send balance to external collections. ☐ Bill to collect from the patient, if unpaid, **SEND Non-Resident balance** to external collections.
EXTERNAL COLLECTIONS **Only applies if sending accounts to collections*
Choose only one:
☐ Send accounts to PBS' contracted collect agency
☐ Use client's contracted agency *(provide agency and contact info below)*
Other procedures/client's contracted agency (if applicable):
Mutual Aid Billing **Only applies if written mutual aid agreement exists for billing (not service alone)*
Client has written Mutual Aid billing agreements with the following agencies:
Copies of written agreements required. Mutual Aid Agency names:

Write off Authorization		
Y	N	*(Check (Y) yes or (N) no & describe other)*
☐	☐	Deceased patients: For Patients deceased on scene, we file a claim with any billable insurance able to be located. (BLS Base/No mileage) Any remaining unpaid charges are written off. If no insurance is located, the call is not billed. Is this acceptable?
☐	☐	Patients who are deceased after transport with remaining balances are written off. Is this acceptable?
☐	☐	Accounts with balances of $24.99 or less are written off. Is this acceptable?

If any "No" was selected on previous page responses, please outline next step procedures:

***Note* Any court ordered bankruptcies or adjustments are automatically written off.**

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Hardships, Medical Records, Subpoenas, Attorney Settlements		
Y	N	*(Check (Y) yes or (N) no & describe other)*
☐	☐	PBS standard procedure will be followed for claims where patient identifies financial hardship/inability to pay.
☐	☐	PBS will process requests for Medical Records from insurance groups & legal representatives
☐	☐	PBS will process subpoenas and present them to the Department/District as required
☐	☐	PBS will process attorney settlement reduction on behalf of the Department/District and seek approval from the Department/District if the reimbursement offer is below standard PBS procedure.

If any "No" was select, please outline next step procedures:

Miscellaneous Billing Support Requests		
Y	N	*(Check (Y) yes or (N) no & describe other)*
☐	☐	On patient invoices, would you like to include a F.D. / F.P.D. logo /crest to your Town's issued statements? If you selected YES, submit a copy of your logo in JPEG format through the Submission Form on your Monday.com FD Board page.
☐	☐	Would you like to include a Resident Letter / Town Letter Signed by the Fire Chief along with your invoices? This is used as an explanation of charges and validation for PBS sending invoice to patient and requesting return mail to be sent to the Lockbox account address.

Access to monthly trip reports, billing invoice, collection and financial data
Allow access to:

NAME	**EMAIL**

Fiscal Calendar
Fiscal Year Begins – End (i.e. May 1- Apr 30)

When does the fire department's calendar begin & end:

Billing Guideline Agreement

PBS & Client Signature

*By signing below, you authorize PBS to bill according to the guidelines outlined above.

Client Signature: _____

Printed Name: _____ **Date:** _____

PBS Representative Signature: _____

Printed Name: _____ **Date:** _____

Billing Rates - _____

Please provide Paramedic Billing Services (PBS) all the specifics of your ordinance to by entering the rates below that are to be charged to individuals and/or businesses inside and/or outside of the department's/district's territory.

Rate Change Effective Date per Ordinance:_____

Will the Rate Change occur on the same date as the Effective Date above: ☐ Yes ☐ No

If No was selected above, provide an effective date for the rate change:_____

EMS Transport Rates		
Name of Charge	**Resident Fee**	**Non-Resident Fee**
BLS Transport		
ALS 1 Transport		
ALS 2 Transport		
Mileage fee		
Other:		
Other:		
Response and TNT charges		
Name of Charge	**Resident Fee**	**Non-Resident Fee**
Response (only) Charge		
Treat No Transport fee		
Other:		
Other:		
Miscellaneous/Other		
Name of Charge	**Resident Fee**	**Non-Resident Fee**
Helipad Charge		
Other:		
Other:		
Other:		

Fire Billing Charges			
Name of Charge	**Resident Fee**	**Non-Resident Fee**	**Per Hour (all veh) or Per Vehicle/Per Hour?**
Rescue Apparatus	$	$	
Rescue Worker per person per hour	$	$	
Consumables/Materials	Yes: ☐ No: ☐	Yes: ☐ No: ☐	
Extrication	$	$	
Other:			

Automatic Rates increases	
No Automatic increase until new ordinance is provided to PBS.	Yes: ☐ No: ☐ If Yes is checked, do not respond to the below 2 sections. If No is checked, please choose response from one of the two sections below
On the calendar date of _____, PBS shall increase your rates by your GEMT rates.	Yes: ☐ No: ☐ If Yes is checked, do not respond to the below section. We will send a new form to complete at that time. If No is checked, please respond to the below section.

PLEASE SEE 2ND PAGE PRIOR TO RETURNING TO PBS

Billing Rates (cont.)

Automatic Rates increases (cont.)		
On the calendar date of _____, PBS shall increase your rates by a specific formula.	Please select only one of the below responses	
	☐	Increase by _____ %
	☐	Medicare increase or _____ % whichever is greater
	☐	Medicare increase or _____ % whichever is less
	☐	CPI increase or _____ % whichever is greater
	☐	CPI increase or _____ % whichever is less
	☐	GEMT or _____ % whichever is greater
	☐	GEMT or _____ % whichever is less

*By signing below, you authorize PBS to bill according to the guidelines outlined above.

Client Signature: _____

Printed Name: _____ Date: _____

PBS Representative Signature: _____

Printed Name: _____ Date: _____