County of Volusia
EVAC Ambulance
112 Carswell Av
Holly Hill, FL 32117
386-252-4900

Guarantee of Payment

This form must be completed on all non-covered, interfacility transfers and submitted, along with the other necessary documentation, to EVAC Ambulance prior to the transport.

Non-emergency transfers require payment at the time of service, either by check, money order, VISA< MasterCard, bank draft, or guarantee of payment by the transferring facility. Medicare does NOT cover most non-emergency transfers; Medicaid requires prior approval of ALL non-emergency transfers. For additional information, please contact EVAC Ambulance at 386-252-4900 during normal business hours.

Date of Transfer: _____

Patient Name: _____

☐ Patient insurance carrier has been contacted and approval for ambulance transport has been obtained. (Please provide all the requested information as EVAC Ambulance will need to confirm the information before transport).

Name of Insurance Carrier _____

Insurance Person Contacted _____

Phone Number: _____

Claim Number: _____

Auth/Per Cert #: _____

☐ Patient is a 100% qualified Hospital Taxing District recipient. (Note: If patient is retroactively approved, then transferring facility will be responsible).

☐ Hospital guarantee payment for services rendered. EVAC Ambulance will NOT fiel any insurance or bill the patient.

Indicate Person and Department Authorizing: _____

☐ Hospital guarantees payment in full, as a last resort, in the event payment is not made by the patient or the patient's insurance carrier within forty-five (45) days.

Indicate Person and Department Authorizing: _____

Individual Completing Form:

Name (Please Print) _____

Title: _____

Date Completed: _____

Signature: _____

Revised: 10/06/11 This document replaces all previous versions