SKILLED NURSING FACILITY PAYMENT AGREEMENT

RETURN FAX TO:614-626-0910

TOPIC OF AGREEMENT
AMERIKARE LLC and **Skilled Nursing Facility**:

(Business Name)_____are in agreement to the following with regards to:

TO PROVIDE PAYMENT FOR SERVICES RENDERED BY PROVIDING MEDICAL TRANSPORTATION ON THE BEHALF OF THE PATIENT IE: AMBULANCE AN/OR AMBULETTE.

PLEASE CIRCLE TYPE OF SERVICE NEEDED: (AMBULANCE) (AMBULETTE)

PATIENT INFORMATION:

NAME:_____
DATES OF SERVICE:_____

TIME OF APPOINTMENT_____

PICK UP LOCATION_____

DROP OFF LOCATION_____

(*PLEASE NOTE IF THIS TRANSPORT IS A WAIT AND RETURN ADDITIONAL CHARGES MAY APPLY* THE FIRST 30 MINUTES ARE INCLUDED IN THE FACILITY RATE)

******OVER THIS WILL BE CHARGED $50.00 PER 15 MINUTES INCREMENTS ******

ANY SPECIAL INSTRUCTIONS:_____
_____

Administrator/Authorized personnel:(PRINT NAME)_____

Administrator/Authorized personnel:(SIGNATURE)_____