MED STAT AMBULANCE, LLC
Appointment Form
Ph: 615-867-1001
Fax: 931-321-2008

Facility Name: _____
Phone Number: _____
Contact:

Patient Name: _____ Room Number: _____

Date/Time of Appointment: _____/_____/_____ _____

Expected length of appointment: _____

Patient Weight/Special Needs/Attachments: _____

_____

Place of Appointment:

Name: _____

Phone Number: _____

Physician/Contact: _____

Address: _____

_____

Wait and Return: ☐ One Way Drop Off: ☐

Insurance Information:

Insurance: _____

Policy/Group Number: _____ Member ID: _____

Med Stat Contact: _____

Med Stat Confirmation Number: _____

NOTES: If Dr visit and Medicare is Primary insurance, facility/patient responsible for payment.
Facility is responsible for any obtaining any authorizations required.