Guardian Angel Ambulance Services, Inc.

411 West Eighth Avenue
Post Office Box 435
West Homestead, PA 15120

Phone (724) 354-2222
or (412) 462-1400
Fax (412) 462-4664

DEPARTMENT OF PUBLIC WELFARE PROOF OF TRANSPORT FORM

Date of Service: _____

Trip Number: _____

This is to prove for the Department of Public Welfare that our patient, _____,

was seen in the office/facility of _____ for _____

on the date of service as indicated above.

Doctor Office/Facility Name: _____

Address of Office/Facility: _____

_____
City *State* *Zip Code*

Office Phone Number: _____

Office Fax Number: _____

Signature of Facility Representative	**Printed Name and Title of Facility Representative**	**Date Signed**
Signature of Driver/Crewmember	**Printed Name of Driver/Crewmember**	**Date Signed**

DOCTOR'S OFFICE/FACILITY:

This patient is receiving benefits from the Department of Public Welfare for these special services. The Department of Public Welfare is now requiring our company to submit proof that the patient was seen in your facility before reimbursement will be provided to us. This form does not constitute as a financial obligation in any way to the person whom signs this form – it is only proof that the patient was seen and treated on this date. If you have any questions, please contact Camilla Ackerson, the Billing/Contract manager for Guardian Angel Ambulance Services, Inc. at (724) 354-2222.