



**ADVANCE DECLARATION FOR  
AMBULANCE TRANSPORTATION SERVICES**

To: \_\_\_\_\_  
(Name of Hospital)

I, \_\_\_\_\_, am of sound mind, and I voluntarily make this Advance Declaration For Ambulance Transportation Services. I intend this declaration to be honored as an expression of my choice. I request that this declaration be made a part of my medical record.

I anticipate that I will need ambulance transportation services during or immediately after my admittance to the above-referenced hospital. I declare that I have chosen Alliance Mobile Health, and its affiliates, as my provider of choice for that ambulance transportation, including any and all transports to and from other medical facilities and at the time of my discharge or release. The only time I do not intend to use Alliance Mobile Health is in the event of (a) an emergency situation which can not practically be accommodated by Alliance Mobile Health, or (b) if non-ambulance transportation is appropriate and I choose such other method of transportation.

This is my predetermined choice in accordance with my rights as a patient to recommend services as required by the Michigan Patient Bill of Rights, MCL 333.20201, and in accordance with my rights under the “Freedom of Choice” provision of the Social Security Act, 42 U.S.C. 1395(a).

Dated: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

ALLIANCE MOBILE HEALTH DISPATCH CENTER  
(888) 843-3772 • OFFICE: (248) 457-0344 x225

**HOSPITAL COPY - white**                      **AMH - yellow**  
*Keep with Patient's Chart*