Sample County FPD #1

c/o Billing Services PO Box 3510 Silverdale, WA 98383
Phone (360) 394-7010 Toll Free (800) 238-9398 Fax (360) 697-1659

INSURANCE INFORMATION REQUEST

Patient Name:	***Phone #:***
Patient Social Security #:	***Patient Birth Date:***

The bill you have received is for ambulance services provided to you or your dependent by the Sample County FPD #1. You are financially responsible for these charges. Your insurance may cover all or part of these charges. If it is convenient for you to send copies of the front and back of your insurance card(s), please do so, as it will provide the necessary information for billing. Complete this form and return it to us promptly at the contact information above. If you have any questions or wish to provide this information to us directly, contact Billing Services at **(360) 394-7010 or (800) 238-9398** M-F from 8:00 AM to 5:00 PM Pacific Time.

PRIMARY INSURANCE ☒ **I do NOT have any insurance applicable to this service.**

Insurance Company Name:			
Claims Address:	***City:***	***State:***	***Zip:***
ID #:	***Group #:***	***Claims Phone #:***	
POLICY HOLDER INFORMATION	***Relation to Patient:*** ☐ ***Self*** ☒ ***Spouse*** ☐ ***Dependent***		
Name:	***Social Security #:***	***Date of Birth:***	

SECONDARY INSURANCE ☐ **I do NOT have any secondary insurance applicable to this service.**

Insurance Company Name:			
Claims Address:	***City:***	***State:***	***Zip:***
ID #:	***Group #:***	***Claims Phone #:***	
POLICY HOLDER INFORMATION	***Relation to Patient:*** ☐ ***Self*** ☒ ***Spouse*** ☐ ***Dependent***		
Name:	***Social Security #:***	***Date of Birth:***	

If this was an auto or work related accident, please check: ☐ ***Auto*** ☐ ***Work***

Auto or Worker's Comp Insurance Name:			
Claims Address:	***City:***	***State:***	***Zip:***
Policy #:	***Claim #****(if known)*	***Claims Adjuster Name:***	
		Claims Phone #:	
POLICY HOLDER INFORMATION	***Relation to Patient:*** ☒ ***Self*** ☒ ***Spouse*** ☐ ***Dependent***		
Name:	***Social Security #:***	***Date of Birth:***	

We must have your signature on file in order to bill your insurance(s). Please sign the other side! →

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Patient Name: _____ **Transport Date:** _____
(Please print)

- ☐ I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by Sample County FPD #1 (SCFPD1) now, in the past, or in the future, until such time as I revoke this authorization in writing.
- ☐ I understand that I am financially responsible for the services and supplies provided to me by SCFPD1 regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance.
- ☐ I agree to immediately remit to SCFPD1 any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to SCFPD1.
- ☒ I authorize SCFPD1 to appeal payment denials or other adverse decisions on my behalf without further authorization.
- ☒ I authorize and direct any holder of medical information or other relevant documentation about me to release such information to SCFPD1 and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by SCFPD1, now, in the past, or in the future. A copy of this form is as valid as an original.

We must have your signature on file in order to bill your insurance(s)

Patient Signature (or Authorized Representative):	
Printed Name:	***Date:***
☐ ***Authorized Representative*** ***(If signing on behalf of patient, please indicate relationship)***	***Relationship:***