***INSURANCE INFORMATION***

***SIGNATURE ON FILE FORM***

Date of Ambulance: Alamo Heights Fire Rescue Patient

Service : Agency: **EMS**  Number:

**Please provide us with any insurance that may aid in paying for your recent ambulance transportation. We will be glad to file any insurance that you may have. However, we lack the necessary information. If you would complete the form below and return it to us we will get your insurance filed promptly.**

If you do not have insurance that will cover ambulance transportation we will be happy to set up a payment plan to take care of your responsibility on this account. You may call us at (210) 824-1281.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | |
| PATIENT INFORMATION Run # | | | | | | | | | | |
| FIRST NAME: | | LAST NAME: | | MIDDLE INITIAL | | DATE OF BIRTH | |  |  | |
|  |  |  | |  | | / / | |  |  |  |
| STREET ADDRESS | | | | SOCIAL SECURITY # | | PHONE NUMBER | | | | |
|  | | | |  | | ( ) | | | | |
| P.O. BOX | | CITY | | STATE, ZIP | | ALTERNATE PHONE NUMBER | | | | |
|  | |  | |  | | ( ) | | | | |
|  | | | | | | | | | | |
| PRIMARY INSURANCE COMPANY OR MEDICARE INFORMATION | | | | | | | | | | |
| INSURANCE NAME | | | POLICY # | | GROUP# | | PHONE # | | | |
|  | | |  | |  | | ( ) | | | |
| POLICY HOLDER NAME | | |  | |  | |  | | | |
| CLAIMS MAILING ADDRESS | | | CITY | | STATE | | ZIP CODE | | | |
|  | | |  | |  | |  | | | |
| SECONDARY INSURANCE INFORMATION | | | | | | | | | | |
| INSURANCE NAME | | | POLICY # | | GROUP# | | PHONE # | | | |
|  | | |  | |  | | ( ) | | | |
| POLICY HOLDER NAME | | |  | |  | |  | | | |
| CLAIMS MAILING ADDRESS | | | CITY | | STATE | | ZIP CODE | | | |
|  | | |  | |  | |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **If this is an auto accident, we will need your Auto Insurance Information.** | | | |
| COMPANY | | AGENT | CLAIM# |
|  | |  |  |
| ADDRESS | CITY | STATE, ZIP | POLICY# |
|  |  |  |  |

Please return this form to us or any additional information written on the reverse side. **If you can send copies of your insurance cards, both front and back,** it will give us the information needed to bill your claim correctly for you.

Print Name of Patient Signature of Patient/ Date

Guarantor-Lifetime Signature

**THANK YOU FOR YOUR HELP!**