INSURANCE REQUEST FORM

CITY OF ALAMO HEIGHTS FIRE/EMS
FOR ASSISTANCE PHONE: (210) 619-1450

PATIENT INFORMATION

NAME: _____ DATE OF SERVICE: _____
ADDRESS: _____
APT/ROOM: _____
CITY/STATE/ZIP: _____
Social Security #: _____ RUN NUMBER: _____

BILL TO

NAME: _____
ADDRESS: _____
APT/ROOM: _____
CITY/STATE/ZIP: _____

MEDICARE AND/OR MEDICAID

MEDICARE ID#: _____
MEDICAID ID#: _____ MEDICAID PLAN: _____

INSURANCE

INSURANCE COMPANY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE #: _____
INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____
ID#: _____ GROUP/POLICY: _____

ADDITIONAL INSURANCE

INSURANCE COMPANY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE #: _____
INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____
ID#: _____ GROUP/POLICY: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF ALL THIRD PARTY BENEFITS TO BE MADE TO THE CITY OF ALAMO HEIGHTS FIRE/EMS WHETHER IN THE PAST, NOW OR IN THE FUTURE.

_____ _____
PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

NOTICE: THIS FORM MUST BE SIGNED BEFORE WE CAN FILE YOUR INSURANCE.