

INSURANCE REQUEST FORM

CITY OF SCHERTZ 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 SCHERTZ 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.