MEDICARE #: **PART B EFF. DATE:** **DATE OF BIRTH:**

MEDICAID ID #: **ISSUE DATE:** **DATE OF BIRTH:**

PRIMARY HEALTH INSURANCE INFORMATION

Company Name:_____Phone:_____

Claim Address:_____ City:_____ St:_____ Zip: _____

Date of Birth: _____ / _____ / _____

I.D.#: Group #: Name of Insured:

SECONDARY HEALTH INSURANCE INFORMATION

Company Name: _____ Phone:_____

Claim Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ / _____ / _____

I.D.#: Group #: Name of Insured:

WAS THIS AN AUTO ACCIDENT? *Yes* ❑ *No* ❑ **WAS THIS WORK RELATED?** *Yes* ❑ *No* ❑

If yes, please provide: Date of Injury _____

Employer:_____ Address:_____ Phone:_____

City: _____ St:_____ Zip:_____

Work Comp/ Auto Insurance
Carrier Name:_____ Address:_____

City:_____ St:_____ Zip:_____

Phone: Adjuster's Name: Claim Number:

ASSIGNMENT OF BENEFITS **NEEDED TO BILL INSURANCE**

I hereby assign to Advanced Medical Transport all my rights and benefits for ambulance services provided by any and all of my insurers and any third party agencies. I further authorize my insurers and any third party agencies to pay directly to Advanced Medical Transport whatever benefits or payments may be available for services rendered to me or my dependents by Advanced Medical Transport.

I hereby authorize any holder of any medical, hospital or other records or information about me or my dependents to release to the Centers for Medicare and Medicaid Services, its intermediaries or other carriers, as well as to Advanced Medical Transport, any such information needed to determine insurance and other third party benefits payable for any services provided to me or my dependents by Advanced Medical Transport or for related services now or in the future.

_____ _____

Dated Signature

PLEASE FILL OUT FOR CHANGE OF ADDRESS

CHANGE OF ADDRESS:

Street: _____City: _____State: _____Zip: _____

Phone: _____