Run #:_____

Northglenn Ambulance
Patient Information Sheet

Patient Name:_____ Alternate Name(s):_____
Date of Birth:_____ Name of Parent/Guardian if Patient is a Minor:_____
Mailing Address:_____ _____ _____ _____
(Street address or PO Box) (City) (State) (Zip)
Phone #:_____ ○ Alternate #:_____ ○ Email:_____ ○
-Please Select Preferred Method of Contact-

****If this was an AUTO ACCIDENT we need both Auto and Medical insurance information to bill correctly****

Primary Insurance information:

Name of Insurance:_____ Member ID #:_____ Group#:_____
Claims Address:_____ _____ _____
(Street Address or PO Box) (City, State) (Zip)

Customer Service #:_____

Secondary Insurance information:

Name of Insurance:_____ Member ID #:_____ Group#:_____
Claims Address:_____ _____ _____
(Street Address or PO Box) (City, State) (Zip)

Customer Service #:_____

Northglenn Ambulance is willing to bill your insurance on your behalf. Please be aware that your contract is between **you** and **your insurance company;** any indifference will need to be worked out between you and your insurance company. Northglenn Ambulance policy requires payments every 30 days on accounts regardless of insurance status.

Assignment of Benefits

****<u>NEEDED TO BILL INSURANCE</u>****

I request that payment of authorized Medicare or any insurance benefits be made whether to me or on my behalf to my medical provider for any services and supplies furnished to me by my medical provider. I authorize any holder of Medical information about me to release to the health Care Financing Administration or any insurance carrier, their agents and carriers as well as my medical provider, any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, now or in the future.

_____ _____
Dated **Signature of Beneficiary, Parent or Guardian**

*Please complete this form and return it in the self addressed stamped envelope immediately to ensure prompt delivery.