

## REQUEST FOR INSURANCE INFORMATION FOR AMBULANCE TRANSPORT

**The hospital does not furnish us with this information.** Do not pay this invoice at this time. Please complete this form and we will file for you. A return envelope is enclosed or to submit this form online go to [www.insupdate.com](http://www.insupdate.com).

Billing Department, P. O. Box 457, Wheeling, IL 60090 (800) 244-2345 Hours: Mon.– Fri. 8:30 a.m. - 4:30 p.m.

### PATIENT INFORMATION *Please print legibly – Thank You! All information is kept confidential.*

**Patient ID #** (from upper right hand corner of Invoice) \_\_\_\_\_ **Date of Service** \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #    -   -

LAST FIRST

*Note:* If your address on the invoice is incorrect, check this box →  and print correct address on back of this form.

Date of Birth (required) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_  
Month Day Year Area Code

Type of Claim: (Check one)  Illness  Auto Accident  Workman's Compensation

### INSURANCE INFORMATION *Please check all that apply. Please print legibly – Thank You!*

I have **MEDICARE** as my (check one)  Primary  Secondary Health Insurance

My Medicare # is \_\_\_\_\_ This is at least a 9 digit number and begins or ends with one or more letters.

*Note:* If you have a Medicare **HMO** please provide a copy of front & back of your HMO Insurance Card. Thank You!

I have **MEDICAID / PUBLIC AID** as my (check one)  Primary  Secondary Health Insurance

My Medicaid # is          This is a 9 digit number that begins with "1" or "0" or "9"

I have **PRIVATE INSURANCE** as my (check one)  Primary Health  Secondary Health  Auto  Workman's Comp

If possible, please provide a copy of the front & back of your Insurance Card. Thank You!

Insurance Co.: \_\_\_\_\_ Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Insurance Co. Phone # ( \_\_\_\_\_ ) \_\_\_\_\_  
Area Code

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Policyholder Soc. Sec. #    -   -     Policyholder Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Patient Relationship to the Policyholder is: check one  Self  Spouse  Child  Other \_\_\_\_\_

Claim # (if an auto accident or workman's compensation) \_\_\_\_\_

I would like to pay by (check one)  VISA  MASTERCARD  DISCOVER CARD

Credit Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_ V-Code (on Back) \_\_\_\_\_

Card Holder Name: \_\_\_\_\_ Billing Address: \_\_\_\_\_

Signature of Card Holder: (required) \_\_\_\_\_

### SIGNATURE AUTHORIZATION **We must have your signature and date on file to bill the above insurance(s) for you.**

I request that payment of authorized benefits be made on my behalf to the MEDICAL SERVICE PROVIDER for any ambulance services and supplies furnished to me. I authorize any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its agents, carriers as well as to the MEDICAL SERVICE PROVIDER. Also, release any information or documentation needed to determine those benefits payable for related services or any services provided me by the MEDICAL SERVICE PROVIDER, now or in the future.

Date: \_\_\_\_\_

Signature of Insured (required): \_\_\_\_\_