Confidential Patient Insurance information Form

Patient Name: _____ Patient Number: _____

Patient Date of Birth: _____ Patient Social Security Number: _____

Primary Insurance

Insurance Name: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Claims address (on back of card): _____

_____

Policy/ID number: _____ Group Number_____

Supplemental Insurance

Insurance Name: _____

Policy Holder: _____ Policy Holder Date of Birth: _____

Claims address (on back of card): _____

_____

Policy/ID number: _____ Group Number_____

Auto/Liability insurance

Insurance Name: _____

Claims address: _____

_____

Adjuster Information: _____ Claim Number: _____

_____

Patient Authorization

I authorize Henderson County EMS to release any information acquired in the course of my examination and treatment in connection with the Ambulance transport for the purpose of insurance, Medicare, Medicaid and/or other benefits payments. The confidential information acquired on this form will be used solely for that purpose. I further authorize payment directly to Henderson County EMS of all benefits applicable and otherwise payable to me for the services rendered. Where Medicare and/or Medicaid benefits are applicable, I certify that the information given by me in applying for payment are correct, and request that said payment of authorized benefits be made on my behalf. I understand that I am responsible to Henderson County EMS for all charges incurred by me. Insurance is filed as a courtesy to the patient. Verification and filing your insurance claim does not guarantee benefits will be paid as stated.

Signature: _____ **Date**: _____

Relationship to patient: _____