REQUEST FOR INSURANCE INFORMATION FOR AMBULANCE TRANSPORT

The hospital does not furnish us with this information.
Billing Department, P. O. Box 457, Wheeling, IL 60090
(800) 244-2345
Hours: Mon.-Fri. 8:30a.m.-7:30p.m. CST

Run #: _____ **Date of Service:** _____

Name: _____ Social Security # ☐☐☐-☐☐-☐☐☐☐

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

IF THIS WAS AN AUTO ACCIDENT OR WORKMAN'S COMPENSATION
PLEASE PROVIDE LIABILITY INSURANCE

To submit your insurance information online go to **www.insupdate.com**
Or complete this form and return it to us at PO Box 457, Wheeling Il 60089

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

Medicare #: _____*This is at least a 9 digit number and begins or ends with one or more letters.*

☐ I have **MEDICAID** *(check one)* ☐ Primary ☐ Secondary Health Insurance

Medicaid #: _____

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

Insurance Co.: _____ Address: _____

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

ID #: _____ Group #: _____ Policyholder Name: _____

Patient relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other Policyholder Date of Birth: _____ / _____ / _____
Month Day Year

Claim # (***if an auto accident or workman's compensation***): _____
Adjuster: _____ Phone #: _____

If you would like to pay by credit card please visit our website at:
https://usapayx.com/insupdate

We accept VISA, MasterCard, Discover Card and American Express.

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 understand that I am financially responsible for the services and supplies provided to me, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to MEDICAL SERVICE PROVIDER. I authorize MEDICAL SERVICE PROVIDER to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to MEDICAL SERVICE PROVIDER and its billing agents, the Centers for Medicare and Medicaid Services and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by MEDICAL SERVICE PROVIDER, now, in the past, or in the future. I also authorize MEDICAL SERVICE PROVIDER to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

Date: _____ Signature of Insured (required): _____

Signature of authorized representative only if patient is physically or mentally incapable of signing:

Please explain why patient is unable to sign: _____

Date: _____ Signature of Authorized Representative: _____ Relationship to patient: _____

All information is kept confidential