

INSURANCE CLAIM INFORMATION

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)

ADDRESS

CITY STATE ZIP

TELEPHONE

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MARITAL STATUS

MARRIED

SINGLE

DIVORCED

SEPARATED

WIDOWED

EMPLOYER'S NAME

EMPLOYER'S TELEPHONE

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EMPLOYER'S ADDRESS

CITY STATE ZIP

INVOICE NUMBER OR INCIDENT NUMBER FROM BILL

ABOUT YOUR INSURANCE:

SOCIAL SECURITY NUMBER

YOUR PRIMARY INSURANCE CO. NAME EFFECTIVE DATE

PRIMARY INSURANCE CO. ADDRESS TELEPHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

YOUR SECONDARY INSURANCE CO. NAME EFFECTIVE DATE

SECONDARY INSURANCE CO. ADDRESS TELEPHONE

CITY STATE ZIP

POLICYHOLDER'S ID NUMBER GROUP PLAN NUMBER

DATE OF EMS SERVICE

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST DIRECT PAYMENT OF MEDICAL BENEFITS TO THE CITY OF LEE'S SUMMIT FOR THE SERVICES PROVIDED BY THE CITY OF LEE'S SUMMIT AMBULANCE SERVICE. THIS AUTHORIZATION APPLIES TO ALL SERVICES PROVIDED BY THE AMBULANCE SERVICE UNTIL IT IS REVOKED BY ME OR MY REPRESENTATIVE.

Signature of insured or authorized person

Date

FAX COMPLETED FORM TO 816-969-1382 OR MAIL TO:
CITY OF LEE'S SUMMIT EMS BILLING
PO BOX 1600
LEE'S SUMMIT, MO 64063-7600

DO NOT E-MAIL THIS FORM AS IT CONTAINS
PERSONAL HEALTH INFORMATION AND THE E-MAIL
MAY NOT BE SECURE.