Account #

Pea Ridge Fire Department
293 S Curtis Ave
Pea Ridge AR 72751

(479)451-1111

This is not a bill

Dear patient or guardian: You (or the patient) were recently transported by ambulance. If we already have insurance/medical coverage information on file for you, then we will bill your insurance provider directly, and this letter is being sent to you as a courtesy notification.

If there is no insurance/medical coverage information shown below, or if the information shown is incorrect, then please fill out (or correct) the information and mail or fax this letter to us at the return address or fax number shown below. You may also call us at the telephone number shown below. Please respond within 30 days.

Once we have your proper insurance/medical coverage information, we will be happy to bill your insurance/medical coverage directly. If you do not have insurance, please call us at the telephone number below to make payment arrangements.

Date of Service ______________________

Patient Name ______________________ **Phone** ______________

Patient Address ______________________

City/State/Zip ______________________

Date of Birth ______________________ **SSN** ______________

Employer/Address ______________________

Employer Phone ______________________

Primary Insurance/Medical Coverage

Insurance Name ______________________

Address ______________________ **Phone** ______________

City/State/Zip ______________________

Policy Holder ______________________ **DOB** ____________ **SSN** ____________

Policy/Member # ______________________ **Group #** ______________

Secondary Insurance/Medical Coverage

Insurance Name ______________________

Address ______________________ **Phone** ______________

City/State/Zip ______________________

Policy Holder ______________________ **DOB** ____________ **SSN** ____________

Policy/Member # ______________________ **Group #** ______________

I acknowledge that I am responsible for paying all charges based on the Ambulance Service Provider's current billing rates. I hereby assign to the Ambulance Service Provider all of my insurance and third party agency benefits for ambulance/EMS services and authorize such benefits to be paid to the Ambulance Service Provider. I authorize the release of any medical, hospital, or other records or information about me or my dependents now or in the future to my insurance/medical coverage providers in order to determine insurance or other third party benefits for ambulance/EMS services to which I or my dependents may be entitled.

Patient/Guardian Signature ______________________ **Date** ______________