Dear Patient:

You have received services from City of Pullman Ambulance. Please complete both pages of this form and return it to City of Pullman Ambulance, 620 South Grand Ave., Pullman, WA 99163. Most insurance companies require a patient or family member signature be on file with our office in order to process an insurance claim.

Financial Responsibility, Benefit Assignment, Information Release

Insurance benefits: I give the City of Pullman permission to bill my insurance or other entity providing benefits to me for the ambulance services I received. My insurance has permission to pay the City of Pullman directly for any services billed. If I or any family member should receive payment for ambulance services provided by the Pullman Fire Department I shall immediately forward such payment to the City of Pullman. I understand that I will be billed and am responsible for payment for any services. Insurance claim filing is done as a courtesy.

Medical personnel as well as staff at the Pullman Fire Department, City of Pullman Finance Department and Information Systems have access to these records in the aspect that pertains to their jobs. The City of Pullman calls patients, patients' families, or other healthcare facilities to obtain further information when not provided or provided incorrectly to complete the billing process. This information is used to bill insurance or collect on unpaid accounts. Copies of medical records are often requested from insurance companies to process a claim and these are sent in a timely manner. I acknowledge that I have been offered a copy of City of Pullman Ambulance Privacy Practices.

Unless otherwise revoked in writing, this waiver will be used for any services provided to you by the City of Pullman.

Patient Signature: _____Date_____
(OR) Authorized
Representative Signature: _____ Date: _____
(Legal Guardian, Immediate Family Relative)
Relationship to Patient: _____

Printed Name:_____ Address:_____

City: _____ State: _____ Zip Code:_____

Phone #: _____ SSN: _____-_____-_____ DOB: ____/___/_____

Please specify the reason patient is unable to sign: _____

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY (FRONT/BACK) AND RETURN IT TO CITY OF PULLMAN AMBULANCE AT 620 S. GRAND AVE., PULLMAN, WA 99163

INSURANCE INFORMATION – CITY OF PULLMAN AMBULANCE

As a courtesy, we bill most insurance companies. However, the patient is responsible for all charges for services provided. If you have insurance, please complete this form and return it to City of Pullman Ambulance, 620 S Grand Ave, Pullman, WA 99163 within 15 days of the receipt of this notice.

Is this an Auto Insurance claim or a Work-related claim? If so, please contact our office at (509) 332-8172 for the appropriate form. This form is for medical insurance only.

City of Pullman Acct #: **RUN**_____-_____ **NAME OF PATIENT:** _____

Patient's Permanent Mailing Address: _____

City, ST, Zip Code: _____

Patient's Phone Number: _____or_____ DOB: _____/_____/_____

SSN: _____-_____-_____ Student ID #: _____Drivers License #: _____

PRIMARY INSURANCE: You may include a copy of your insurance card (front and back) in lieu of written information. *Please indicate which insurance is Primary and which insurance is Secondary on the copy*.

Insured Name (EXACTLY as it appears on the insurance card): _____

Patient's Relationship to Insured: Self Spouse Child Other

Name of Insurance Company: _____

Insurance ID # (provide ALL prefix and suffix letters and numbers):_____

Insurance Group/Plan #: _____ Insurance Phone #: _____

Insurance Claims Address: _____

City, ST, Zip Code: _____

SECONDARY INSURANCE: You may include a copy of your insurance card (front and back) in lieu of written information. *Please indicate which insurance is Primary and which insurance is Secondary on the copy*.

Insured Name (EXACTLY as it appears on the insurance card): _____

Patient's Relationship to Insured: Self Spouse Child Other

Name of Insurance Company: _____

Insurance ID # (provide ALL prefix and suffix letters and numbers):_____

Insurance Group/Plan #: _____ Insurance Phone #: _____

Insurance Claims Address: _____

City, ST, Zip Code: _____

Signature: _____**Date:** _____/_____/_____