MEDICARE #: **PART B EFF. DATE:** **DATE OF BIRTH:**

MEDICAID ID #: **ISSUE DATE:** **DATE OF BIRTH:**

PRIMARY HEALTH INSURANCE INFORMATION

Company Name:______________________________ Phone:______________________

Claim Address:______________________________ City:______________ St:_______ Zip: ________

Date of Birth: ______ / ______ / ______

I.D.#: Group #: Name of Insured:

SECONDARY HEALTH INSURANCE INFORMATION

Company Name: ______________________________ Phone:______________________

Claim Address: ______________________________ City: ______________ St: _______ Zip: _________

Date of Birth: ______ / ______ / ______

I.D.#: Group #: Name of Insured:

WAS THIS AN AUTO ACCIDENT? *Yes* ❏ *No* ❏ **WAS THIS WORK RELATED?** *Yes* ❏ *No* ❏

If yes, please provide: Date of Injury ______________

Employer:______________________________ Address:______________________ Phone:____________

City: ______________________ St:________ Zip:________

Work Comp/ Auto Insurance
Carrier Name:______________________________ Address:______________________________

City:______________________ St:________ Zip:________

Phone: Adjuster's Name: Claim Number:

ASSIGNMENT OF BENEFITS **NEEDED TO BILL INSURANCE**

I hereby assign to Advanced Medical Transport Of Iowa all my rights and benefits for ambulance services provided by any and all of my insurers and any third party agencies. I further authorize my insurers and any third party agencies to pay directly to Advanced Medical Transport Of Iowa whatever benefits or payments may be available for services rendered to me or my dependents by Advanced Medical Transport Of Iowa.

I hereby authorize any holder of any medical, hospital or other records or information about me or my dependents to release to the Centers for Medicare and Medicaid Services, its intermediaries or other carriers, as well as to Advanced Medical Transport Of Iowa, any such information needed to determine insurance and other third party benefits payable for any services provided to me or my dependents by Advanced Medical Transport Of Iowa or for related services now or in the future.

__________________ ____

Dated Signature

PLEASE FILL OUT FOR CHANGE OF ADDRESS

CHANGE OF ADDRESS:

Street: ______________________________City: ______________State: _______Zip: ______________

Phone: ________________