

ORANGE CO REVENUE- AMBULANCE SERV. EMS

PO BOX 8181  
HILLSBOROUGH, NC 27278-8181  
(919) 245-2728

Customer:

Re: Run Number: Date of Service: Amount Due:

DO NOT CALL WITH YOUR INSURANCE INFORMATION. IT MUST BE GIVEN IN WRITING WITH THE PATIENT'S SIGNATURE ACCORDING TO FEDERAL LAW. If you have received this form, we do not have complete insurance information. Please complete, sign and return this form to the address above as soon as possible so we may file this claim to your insurance. Make certain that your policy and group numbers are complete just as written on your card. Without complete insurance information, we cannot file insurance on your behalf. IF YOU DO NOT PROVIDE YOUR INSURANCE INFORMATION NOW, YOU WILL BE RESPONSIBLE FOR THIS BILL.

Patient's First Name Middle Name Last Name

Date of Birth: Social Security Number: Telephone

Address: City State Zip Code

Medicare #: Medicaid Recipient ID:

Name of Insurance Company:

Address: City State Zip Code

Policy Number: Group Number:

Insurance Policy Holder's Name and Date of Birth

Check if Ambulance Transportation was connected to:

Worker's Comp: Auto Accident: Other Accident:

By signing this form, you expressly consent to our use and disclosure of your health information for purposes of treatment, payment or other health care operations. You have the right to revoke this consent at any time; however revocation will not be effective regarding services which we have already provided based on this signed consent form, because we are relying on your consent in providing services to you. If you wish to revoke this consent, you must do so in writing sent to our address above. Unless revoked, this consent will not expire and will apply to all services provided to you from this day forward for Orange County Emergency Management Service.

Name (please print) Signature Date

PATIENT, LEGAL GUARDIAN, OR POA ONLY CAN SIGN THIS FORM  
SIGNATURE REQUIRED TO FILE CLAIM TO YOUR INSURANCE