Orange County Revenue – Ambulance Service
228 South Churton Street, Suite 200
PO Box 8181, Hillsborough, NC 27278-8181
Phone: 919-245-2100 opt 3 Fax: 919-644-3332 Email: tax@orangecountync.gov

Medical Release Insurance Form

Responsible Party/Guarantor:

*Run Number: Date of Service: Amount Due:

FEDERAL LAW REQUIRES THAT WE HAVE YOUR INSURANCE INFORMATION IN WRITING ALONG WITH YOUR SIGNATURE IN ORDER TO FILE A CLAIM FOR YOUR AMBULANCE TRIP. WE ARE UNABLE TO ACCEPT YOUR INSURANCE INFORMATION BY PHONE. 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 insurance card. Without a complete insurance form, we cannot file a claim on your behalf.

IF YOU DO NOT PROVIDE YOUR INSURANCE INFORMATION NOW, YOU WILL BE RESPONSIBLE FOR THE ENTIRE BILL AMOUNT.

Patient's Name:
Last First Middle

Date of Birth Social Security Number Telephone

Mailing Address City State Zip

Primary Coverage

Medicare Number | **Medicaid Recipient ID**

Commercial Insurance Company:

Mailing Address City State Zip

Policy Number | Group Number

Insurance Policyholder's Name | Insurance Policyholder's Date of Birth

Secondary Coverage

Medicare Number | **Medicaid Recipient ID**

Commercial Insurance Company:

Mailing Address City State Zip

Policy Number | Group Number

Insurance Policyholder's Name | Insurance Policyholder's Date of Birth

Worker's Comp or Auto Liability Coverage

Attorney's Name or Auto Insurance Company:

Mailing Address City State Zip

Policy Number (Auto Insurance) | Claim Number (Worker's Comp)

Insurance Policyholder's Name | Contact Phone Number

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 to the address above. This consent will apply to services provided to you for this particular ambulance trip (*see Run Number above) with Orange County Emergency Service.

Signature Printed Name Date

PLEASE INCLUDE A **FRONT & BACK** COPY OF YOUR INSURANCE CARD WHEN RETURNING THIS FORM