In order to process your claim, please provide your insurance information below and mail the form to SINGERLY FIRE COMPANY, PO Box 7236, Lancaster PA 17604 or fax it to 614-987-2075. To view your account online, go to ambulancebilling.com

Do you have insurance? Yes ☐ No ☐ (If you ***do not*** have insurance, complete only the **Patient Information** section.)

Patient Information (Required Information)

Patient's First Name | MI | Patient's Last Name | Patient's Sex **M** ☐ **F** ☐

Patient's Date of Birth (MM-DD-YYYY) ___ - ___ - ___

Patient's Social Security Number ___ - ___ - ___

Telephone Number (Include Area Code) ___ - ___ - ___

E-mail Address

I authorize any holder of medical or other information about me to release to Medicare, Medicaid or any other payer responsible for payment and any information needed for this related Medicare or other claim, now, in the future or in the past. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the service provider.

Signature ______________________ Date ______________________

Signer's relationship to patient: Self ☐ Parent ☐ Other ☐ If other, please explain: ______________

Signer's Address:________________City:______________ State:_____ Zip Code:______

Medicare Information

Medicare ID (Include letters and numbers) | Railroad ☐

Medicaid Information

Medicaid ID (Include letters and numbers) | State

Patient Insurance Information

Policy Holder's First Name | MI | Policy Holder's Last Name

Patient's Relationship to Insured: Self ☐ Spouse ☐ Other ☐

Insurance Company Name | Primary ☐ Secondary ☐

Insurance Policy Number | Insurance Group Number

Insurance Company Address

City | State | ZIP Code

Patient Accident/Injury Insurance Information

If services were related to an accident or injury, please provide any additional insurance information, such as homeowners, automobile, workers' compensation, or liability.

Policy Holder's First Name | MI | Policy Holder's Last Name

Patient's Relationship to Insured: Self ☐ Spouse ☐ Other ☐

Insurance Company Name | Insurance Contact Phone Number ___ - ___ - ___

Insurance Policy Number | Claim Number

Insurance Company Address

City | State | ZIP Code

At-fault Party's Accident/Injury Insurance Information

If services were related to an accident or injury, please provide any additional insurance information for the **responsible party**, such as homeowners, automobile, workers' compensation, or liability.

Policy Holder's First Name | MI | Policy Holder's Last Name

Patient's Relationship to Insured: Self ☐ Spouse ☐ Other ☐

Insurance Company Name | Insurance Contact Phone Number ___ - ___ - ___

Insurance Policy Number | Claim Number

Insurance Company Address

City | State | ZIP Code