

Town of Shirley Ambulance Dept INSURANCE INFORMATION FORM

Today's date:		ACCT #:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
		Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /
			Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:	Home phone no.: ()
P.O. box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ()	

INSURANCE INFORMATION			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ()

Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please indicate primary insurance	
<input type="checkbox"/> Medicare	<input type="checkbox"/> Mass Health
<input type="checkbox"/> BCBS	<input type="checkbox"/> HPHC
<input type="checkbox"/> Tricare	<input type="checkbox"/> Other
<input type="checkbox"/> Cigna	<input type="checkbox"/> Network Health
<input type="checkbox"/> Fallon	<input type="checkbox"/> Tufts
Subscriber's name:	Subscriber's S.S. no.:
Birth date: / /	Group no.:
Policy no.:	
Patient's relationship to subscriber:	<input type="checkbox"/> Self
<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):	Subscriber's name:
Group no.:	Policy no.:
Patient's relationship to subscriber:	<input type="checkbox"/> Self
<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
<input type="checkbox"/> Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to The Town of Shirley Ambulance. I understand that I am financially responsible for any balance. I also authorize The Town of Shirley Ambulance or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

