County of Sandoval Ambulance Billing
Payment Information Form

Completed forms may be sent to: PO BOX 639, Bernalillo NM 87004 – or faxed to: (505) 867-6256

Please fill out the following form as completely and as accurately as possible. As a courtesy, the county will file ambulance claims to your insurance company, but this does not guarantee payment. We recommend that you contact your insurance company to determine if your policy covers charges incurred through the county's ambulance services. It is vital to provide as much information as possible for proper filing of your claim. Your claim may be rejected without this information. **Please include a copy of your insurance card (both sides) when submitting this form.**

Required Information:

Patient's Printed Name: _____
(Last) (First) (Middle)

Signature: _____ **Date:** _____

Consent for Billing - My signature above authorizes the release to the Social Security Administration and Centers for Medicare and Medicaid Services, any HMO/PPO, other private or public insurance, or their agents, fiscal intermediaries or carriers or an independent agency performing billing or collection functions on behalf of the County of Sandoval ambulance service, any personal, medical or billing information needed for this or a future claim. I understand I will be responsible for any services that are not paid/covered by my insurance. A copy of this authorization shall be valid as the original and shall remain in effect until revoked in writing by the patient/insured. I request payment of medical insurance benefits either to me or to the ambulance service.

Home Address: _____
(Street) (City) (State) (Zip)

Phone Number: (___) _____ Date of Birth: ___/___/___

Incident Date: ___/___/___ Account (Call) Number: _____

Note: It is imperative that you provide your Call #, incident date, and/or date of birth to ensure that your claim is billed accurately.

Primary Insurance Information:

Medicare / Social Security Number (If Applicable): _____

Insurance Company Name: _____

Member Number: _____ Group Number (If Applicable): _____

Insurance Company Mailing Address: _____
(Street) (City) (State) (Zip)

Insurance Company Phone No.: (___) _____ Fax No. (If Known) (___) _____

Secondary Insurance Information (If Applicable)**:**

Insurance Company Name: _____

Member Number: _____ Group Number (If Applicable): _____

Insurance Company Mailing Address: _____
(Street) (City) (State) (Zip)

Insurance Company Phone No.: (___) _____ Fax No. (If Known) (___) _____
