**Account Information**

| | |
|---|---|
| Account Number: | ####*######.1 |
| Patient Name: | John Doe |
| Statement Date: | 02/07/23 |
| Type of Service: | Ambulance |
| Service Date: | 01/01/23 |

# *Request for Information*

Dear JOHN DOE,

On the above date you were transported by MIAMI VALLEY JOINT FIRE DISTRICT to KETTERING MEDICAL CENTER. Please provide your insurance information on our website at https://www.peryourhealth.com or provide your insurance information on the back of this form so we may submit a claim for payment on your behalf. We need your signature to file your claim. Please log on to our website with the ID and access key provided below to provide insurance information and confirm your signature or complete the back of this form, sign below and return to MIAMI VALLEY JOINT FIRE DISTRICT.

If you have questions please call us at (855) 626-9660 8:30AM - 5:30PM, MONDAY THROUGH FRIDAY. Thank you for your prompt response to this request.

**ASSIGNMENT OF CLAIM AND AUTHORIZATION - PROVIDE INSURANCE INFORMATION**

I request that payment of authorized Medicare, Medicaid or any other insurance benefits be made on my behalf to MIAMI VALLEY JOINT FIRE DISTRICT for any services provided to me now, in the past, or in the future, until such time as I revoke this authorization in writing. I agree to immediately remit to MIAMI VALLEY JOINT FIRE DISTRICT any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to MIAMI VALLEY JOINT FIRE DISTRICT. I authorize MIAMI VALLEY JOINT FIRE DISTRICT to appeal payment denials or other adverse decisions on my behalf without further authorization. A copy of this form is as valid as the original. I understand MIAMI VALLEY JOINT FIRE DISTRICT is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations.

Signature:_____ Relationship to Patient:_____ Date:_____

Visit us at https://www.peryourhealth.com to electronically sign, update your insurance, address, view your account, or send a message to our billing office. ID: ####*######### Access key: BB##6#

## CONTACT US

Phone: (855) 626-9660 8:30AM - 5:30PM,
MONDAY THROUGH FRIDAY

*Fold on line for proper window alignment*

**We need your assistance!**
**You can help us, with just 3 easy steps:**

**1. Please sign and date the form above.**

**2. Fill out your insurance information on the back of this form.**

**3. Place completed form in return envelope provided and mail. Thank you!**

MIAMI VALLEY JOINT FIRE DISTRICT
ATTENTION 5803
PO BOX 3484
TOLEDO, OH 43607-0484

Temp - Return Service Requested

0101

JOHN DOE
1234 ANY STREET
ANYTOWN, OH 45402-5123

MIAMI VALLEY JOINT FIRE DISTRICT
C/O CHANGE HEALTHCARE
4720 SALISBURY RD STE 121
JACKSONVILLE, FL 32256

10318-MCKSTM1-770819-295706611-; 1882766-1-1713; 295706611_6; 1

840611 (PC0)

**Account Information**

| | |
|---|---|
| Account Number: | ####*1########.1 |
| Patient Name: | JOHN DOE |
| Statement Date: | 02/07/23 |
| Type of Service: | Ambulance |
| Service Date: | 01/01/23 |

Patient's Date of Birth: _____

Patient's Phone Number: _____

Patient's SSN: _____

**PRIMARY INSURANCE INFORMATION**

Company*: _____

Telephone #: _____

Address: _____

City/St/Zip:_____

Policy #: _____

Group #:_____

Policy Holder's Name: _____

Relationship to Patient: _____

Insured's SSN: _____

Insured's Date of Birth: _____

**SECONDARY INSURANCE INFORMATION**

Company*: _____

Telephone #: _____

Address: _____

City/St/Zip: _____

Policy #: _____

Group #: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Insured's SSN: _____

Insured's Date of Birth: _____

*** If you have Medicare or Medicaid and have a Managed Care replacement plan please provide that information above.**

**If the services provided were a result of a work related or motor vehicle accident, please also provide the appropriate information below.**

**AUTOMOBILE INSURANCE INFORMATION**

Company: _____

Telephone #: _____

Address: _____

City/St/Zip: _____

Policy #: _____

Claim #: _____

Policy Holder's Name: _____

Relationship to Patient: _____

Original Date of Accident: _____

State where Original Accident Occurred: _____

**WORKER'S COMPENSATION INFORMATION**

Employer: _____

Employer Address: _____

City/St/Zip: _____

Employer Phone #: _____

Workers Comp Carrier: _____

Carrier Phone#: _____

Carrier Address: _____

City/St/Zip: _____

Policy #: _____

Claim #: _____

Original Date of injury: _____