ACTION REQUIRED

Tempe Fire Medical Rescue
Remittance Address
PO BOX 29650
Dept #880170
PHOENIX AZ 85038-9650
800-814-5339

Pay your bill now by going to:
www.emsbilling.com/patient-portal

ACCOUNT DETAILS

Run #: 15-1234567 Date of Service: 09/02/2015
Patient Name: LONNIE SAMPLE

To: 312 MAIN ST
ROCKWELL, NC 281380000
From: 312 MAIN ST
ROCKWELL, NC 281380000

Total Charges: $140.00

PLEASE PAY THIS AMOUNT $140.00

Description	Qty.	Price	Allowance	Amount
Treatment, No Transport - ROCA	1	$140.00		$140.00

8784PSMT_3 2/9/16 CMYK 3.5"

Tell us what you thought about your EMS experience:
https://emsecurepay.emsbilling.com/survey

PLEASE PAY THIS AMOUNT $140.00

WE DO NOT HAVE YOUR INSURANCE ON FILE

You may provide your insurance in one of the following ways: **1)** Visit our website at www.emsbilling.com/patient-portal, **2)** Complete the back side of this form in its entirety and return to us, or **3)** Call our automated telephone system at **800-814-5339**, which is available 24 hours a day or speak to one of our Customer Service Specialists Monday through Friday 8:00 a.m. to 8:00 p.m. eastern time. If you do not have insurance, you are responsible for the amount due. You can make a payment online or by contacting our Customer Service Department. **Para asistencia en español por favor llame a sevicio al cliente al 800-814-5339.**

DETACH LOWER PORTION AND RETURN STUB WITH YOUR PAYMENT. THANK YOU.

DO NOT SEND PAYMENTS TO THIS ADDRESS
Tempe Fire Medical Rescue
PO BOX 1028
MOUNT AIRY NC 27030-1028
ELECTRONIC SERVICE REQUESTED

PATIENT / GUARANTOR NAME			AMOUNT DUE
LONNIE SAMPLE			$140.00
RUN #	**DATE OF SERVICE**	**STATEMENT DATE**	**AMOUNT ENCLOSED**
15-1234567	09/02/2015	07/18/2017	$

WE ACCEPT VISA MasterCard DISCOVER PLEASE SEE REVERSE SIDE FOR DETAILS

4695387 8784-SMT 14 1 2 1

LONNIE R SAMPLE
PO BOX 123
ROCKWELL NC 28138-0123

PLEASE MAKE CHECKS PAYABLE TO:

Tempe Fire Medical Rescue
PO BOX 29650
Dept #880170
PHOENIX AZ 85038-9650

Federal Tax ID: 86-6000262
Incident Number: 6A95B000-001B-1234-0

4695387-14-1-1*

Attention:

*In order to file health insurance on your behalf, your signature is **REQUIRED.***

I request that payment of authorized Medicare, Medicaid or any other insurance benefits be made on my behalf to Tempe Fire Medical Rescue for any services provided to me by Tempe Fire Medical Rescue now, in the past, or in the future. I understand that I am financially responsible for the services provided to me by Tempe Fire Medical Rescue, regardless of my insurance coverage and in some cases, may be for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Tempe Fire Medical Rescue 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 Tempe Fire Medical Rescue. I authorize Tempe Fire Medical Rescue to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to Tempe Fire Medical Rescue and its billing agents, and/or the Centers for Medicare & Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Tempe Fire Medical Rescue now or in the future. A copy of this form is as valid as an original.

Patient or authorized representative signature: _____

Printed Name of person signing: _____ Date: _____

Relationship to patient:

☐ Self	☐ **Relative/Other
☐ Patient's Legal Guardian/Healthcare Power of Atty	☐ Person receiving govt. benefits on behalf of the patient

****If Relative/Other please list the reason patient was incapable of signing:** _____

Insurance Information:	**Any Additional Insurance:**
Type: ☐ Medicare ☐ Medicaid ☐ Insurance Name: _____	Type: ☐ Medicare ☐ Medicaid ☐ Insurance Name: _____
Name of Insured/Guarantor Policy Holder:	Name of Insured/Guarantor Policy Holder:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Insurance Policy #:	Insurance Policy #:

Third Party Liability Insurance:

If accident related, what type of insurance are you providing information for?

☐ Workers Compensation ☐ Auto ☐ Other Insurance

Name: _____

Name of Insured/ Policy Holder:	Policy Holder's Date of Birth:
Case/Claim Number #:	Policy Holder's Employer (if applicable):
Employer's Name and Address:	Employer's Telephone #:
Claim Mailing Address:	Insurance Co. Telephone #:

Credit Card Payment Information:

Credit card payments can **only** be made at **www.emsbilling.com/patient-portal** or by calling 800-814-5339. Payment via our website will provide a confirmation number and option of emailed payment verification. Credit card payments returned by mail will not be processed.