MEDICAID ID #: ISSUE DATE: DATE OF BIRTH: PRIMARY HEALTH INSURANCE INFORMATION	MEDICARE #:	PART B EFF. DATE		DATE OF BIRTH	I:
Company Name:	MEDICAID ID #:	ISSUE DATE:		DATE OF BIRTH	
Claim Address:	PRIMARY HEALTH INSURANCE	INFORMATION		- Ma-, '.	
Date of Birth:// LD.#:	Company Name:			_Phone:	
ECONDARY HEALTH INSURANCE INFORMATION Company Name:	Claim Address:		City:	St:	Zip:
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Company Name:	I.D.#; Gre	oup #:	Name	of Insured:	
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MAS THIS AN AUTO ACCIDENT? WAS THIS WORK RELATED? WAS THIS WORK RELATED? WAS THIS WORK RELATED? Was THIS WORK RELATED? Yes No Accidence of Injury Employer: Address: City: St: Zip: City: St: Zip: Phone: Address: City: St: Zip: Phone: ASSIGNMENT OF BENEFITS **NEEDED TO BILL INSURANCE** I hereby assign to Medics First all my rights and benefits for ambulance services provided by any and all of my insurers and any third party agencies. I further authorize my insurers and any third party agencies to pay directly to Medics First whatew benefits or payments may be available for services rendered to me or my dependents by Medics First. Hereby authorize any holder of any medical, hospital or other records or information about me or my dependents to release the Centers for Medicare and Medicaid Services, its intermediaries or other carriers, as well as to Medics First, any sucinformation needed to determine insurance and other third party benefits payable for any services provided to me or m dependents by Medics First or for related services now or in the future. Dated Signature Signature City: State: Zip: Zip:	Claim Address:	Ci	ty:	St:	Zip:
WAS THIS AN AUTO ACCIDENT? Yes No WAS THIS WORK RELATED? Yes No	Date of Birth:///				
Employer: Address: Phone: Phone: City: St: Zip: Work Comp/ Auto Insurance Carrier Name: Address: St: Zip: Address: St: Zip: Phone: Address: City: St: Zip: St: Zip: Phone: Adjuster's Name: Claim Number: ASSIGNMENT OF BENEFITS **NEEDED TO BILL INSURANCE** I hereby assign to Medics First all my rights and benefits for ambulance services provided by any and all of my insurers and any third party agencies to pay directly to Medics First whatev benefits or payments may be available for services rendered to me or my dependents by Medics First. I hereby authorize any holder of any medical, hospital or other records or information about me or my dependents to release the Centers for Medicare and Medical Services, its intermediaries or other carriers, as well as to Medics First, any sucinformation needed to determine insurance and other third party benefits payable for any services provided to me or in dependents by Medics First or for related services now or in the future. Dated Signature PLEASE FILL OUT FOR CHANGE OF ADDRESS CHANGE OF ADDRESS: Street:	I.D.#: Gro	oup #:	Name	of Insured:	
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ASSIGNMENT OF BENEFITS **NEEDED TO BILL INSURANCE** I hereby assign to Medics First all my rights and benefits for ambulance services provided by any and all of my insurers and any third party agencies to pay directly to Medics First whatever benefits or payments may be available for services rendered to me or my dependents by Medics First. I hereby authorize any holder of any medical, hospital or other records or information about me or my dependents to release the Centers for Medicare and Medicaid Services, its intermediaries or other carriers, as well as to Medics First, any sucinformation needed to determine insurance and other third party benefits payable for any services provided to me or medicants by Medics First or for related services now or in the future. Dated Signature PLEASE FILL OUT FOR CHANGE OF ADDRESS CHANGE OF ADDRESS: Street:		City:	· 	St:	Zip:
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