



Midwest Ambulance Service, Inc

P.O. Box 421723, Indianapolis, IN 46242

Phone: 317.548.4044

www.midwestambulance.org

Fax: 317.857.1481

Medical Insurance Information Patient Information

If you have insurance coverage (Medical, Automobile, or Workman's Comp), please complete this form. **PRINT CLEARLY**, and return to one of the addresses below so we can file your insurance claim. This form must be complete with a signature. If you have any questions, call Midwest Ambulance Service at 317-548-4044 or fax us at 317-857-1481.

Patient Name

Account #

Patient's Martial Status (Circle One): Single Married Other

Your signature acknowledges permission to bill your insurance.

Signature of Patient, Guardian, or Responsible Party:

X _____

Date: _____

Primary Insurance Company Information:

Primary Insurance Name: _____

Claim Address: _____

Insurance phone #: _____

Identification #: _____

Member/Group #: _____

Employer: _____

Employer phone #: _____

Primary Insured Information:

Insured Name: _____

Insured Address: _____

Phone #: _____

Date of Birth: _____

Patient's relationship to insured: _____

Secondary Insurance Company Information:

Secondary Insurance Name: _____

Claim Address: _____

Insurance phone #: _____

Identification #: _____

Member/Group #: _____

Employer: _____

Employer phone #: _____

Secondary Insured Information:

Insured Name: _____

Insured Address: _____

Phone #: _____

Date of Birth: _____

Patient's relationship to insured: _____

Please complete and mail to: Midwest Ambulance

PO Box 421723

Indianapolis, IN 46242

Fax completed form to: 317-857-1481

Or email completed form to: ann.mcalister@midwestambulance.org