CITY OF LONG BEACH

DEPARTMENT OF FINANCIAL MANAGEMENT

333 West Ocean Boulevard, Lobby Level • Long Beach, CA 90802 • Phone (562) 570-7600 • Fax (562) 570-6783

Emergency Ambulance Service - Request for Medical Insurance Information

Please note that charges for the recent emergency medical services provided by the Long Beach Fire Department are now due for payment. Please provide medical insurance information requested on this form so that we may bill your insurance provider for the charges listed on your bill. If you do not provide the required medical insurance information, you will be responsible to pay the billed charges by the due date.

Please fill out the form below and return to our office promptly. Please mail the form to City of Long Beach, Attn: Ambulance Billing, P.O. Box 22600, Long Beach, CA 90801 or email it to the City at AmbulanceBilling@LongBeach.gov. Also, please include a front and back copy of your insurance card(s) if possible.

Primary Insurance

Type of Insurance:_____

Insurance Company Name:_____

Member Number/Claim Number/Policy Number:_____

Address:_____ City:_____

State:____ Zip Code:_____ Phone Number:_____

Secondary Insurance

Type of Insurance:_____

Insurance Company Name:_____

Member Number/Claim Number/Policy Number:_____

Address:_____ City:_____

State:____ Zip Code:_____ Phone Number:_____

Additional Insurance to Bill

Type of Insurance:_____

Insurance Company Name:_____

Member Number/Claim Number/Policy Number:_____

Address:_____ City:_____

State:____ Zip Code:_____ Phone Number:_____

Authorization for release of Medical Information:

I authorize any holder of Medical information about me to release to Medicare, Medicaid and any insurance, as well as the provider of this service, any information or documentation in their possession needed to determine these benefits or the benefits payable for related service, whether in the past, now, or in the future.

_____ _____

Signature of Patient, Guarantor, Parent, or Guardian Print Name

_____

Date

Run #_____

(Located on bill, under Patient Name)

PRINT