CITY OF LONG BEACH

Department of Financial Management
Commercial Services Bureau
411 West Ocean Boulevard, Lobby, Long Beach, CA 90802
(562) 570-7600 • Fax: (562) 570-6783 • AmbulanceBilling@LongBeach.gov

Emergency Ambulance Transport Billing Information Form

Please complete this form by signing **Section 1 or 2** and providing patient medical insurance information in **Section 3**. If this completed form is not returned to us within **30 days** of the date of service, you will be held responsible for all charges. Please submit this document via mail to the City of Long Beach, Attn: Ambulance Billing, P.O. Box 22600, Long Beach, CA 90801, via fax (562) 570-6783, or via email to AmbulanceBilling@LongBeach.gov.

Section 1 - Patient Signature

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: If the patient is a minor, the parent or legal guardian should sign this section.

I authorize any holder of medical information about me to release to Medicare, Medicaid and any insurance, as well as the Long Beach Fire of this service, any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, whether in the past, now or in the future. I also consent to being contacted by Long Beach Fire or by any agent acting on behalf of Long Beach Fire, by telephone, cell phone, or other methods of communication, in connection with the billing or collection of amounts due, or otherwise in connection with the services rendered by Long Beach Fire, including calls to any cellular phone, and including any such calls made using an automatic telephone dialing system, texting or prerecorded voice. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

_____	_____	_____
Print Name of Patient	Patient Signature	Date

Section 2 - Authorized Representative Signature

Complete this section only if the patient is physically or mentally incapable of signing.

Describe the circumstance that make it impractical for the patient to sign:_____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid or any other payer for any services provided to the patient by Long Beach Fire now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

Authorized representatives include only the following individuals:
□ Patient's legal guardian
□ Relative or other person who receives social security or other governmental benefits on behalf of the patient
□ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
□ Representative of an agency or institution that did not furnish the services for which payment is claim (i.e., ambulance services) but furnished other care, services, or assistance to the patient

_____	_____	_____
Print Name of Representative	Representative Signature	Date

Section 3 - Insurance Information

Please provide patient medical insurance information below and return this form, along with a copy of any insurance identification cards.

Primary Insurance:
Insurance Company Name:_____
Member Number/Claim Number/Policy Number:_____
Address:_____

Secondary Insurance:
Insurance Company Name:_____
Member Number/Claim Number/Policy Number:_____
Address:_____

Run Number (Located on bill, under patient name):_____ Date of Service:_____