INSURANCE REQUEST FORM

CITY OF SAN ANTONIO EMERGENCY MEDICAL SERVICE
FOR ASSISTANCE PHONE: (210) 227-7252
FAX (210) 224-6945

*** THIS FORM **MUST BE COMPLETED AND SIGNED** IN ORDER FOR YOUR INSURANCE TO BE FILED ***
** IF THIS IS A **WORKER'S COMPENSATION CLAIM,** PLEASE CALL THE NUMBER ABOVE **

E.M.S. ACCOUNT NUMBER:	DATE OF SERVICE:
PATIENT NAME:	
PATIENT'S ADDRESS:	
PATIENTS CITY, STATE, ZIP:	
PATIENT'S HOME PHONE:	PATIENT'S WORK PHONE:
PATIENT'S SOCIAL SECURITY NUMBER:	
PATIENT'S DATE OF BIRTH:	

INSURANCE #1	
INSURANCE COMPANY NAME:	
INSURANCE ADDRESS:	
CITY, ST, ZIP	INSURANCE PH.#:
INSURED'S NAME:	RELATIONSHIP TO PATIENT:
ID#:	GROUP OR POLICY#:

INSURANCE #2	
INSURANCE COMPANY NAME:	
INSURANCE ADDRESS:	
CITY, ST, ZIP	INSURANCE PH.#:
INSURED'S NAME:	RELATIONSHIP TO PATIENT:
ID#:	GROUP OR POLICY#:

INSURANCE #3	
INSURANCE COMPANY NAME:	
INSURANCE ADDRESS:	
CITY, ST, ZIP	INSURANCE PH.#:
INSURED'S NAME:	RELATIONSHIP TO PATIENT:
ID#:	GROUP OR POLICY#:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF ALL THIRD PARTY BENEFITS TO BE MADE TO THE CITY OF SAN ANTONIO EMERGENCY MEDICAL SERVICE.

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PATIENT OR AUTHORIZED PERSON'S SIGNATURE DATE

NOTICE: THIS FORM MUST BE COMPLETELY FILLED OUT AND SIGNED BEFORE WE CAN FILE YOUR INSURANCE