

City of Schertz EMS
Insurance Request Form
Phone: (210) 619-1450
Fax: (210) 619-1499

PATIENT INFORMATION

NAME: _____ RUN NUMBER _____
ADDRESS: _____
CITY/STATE/ZIP: _____
SOCIAL SECURITY #: _____

MEDICARE AND/OR MEDICAID

MEDICARE ID #: _____
MEDICAID ID #: _____ MEDICAID PLAN: _____

INSURANCE

INSURANCE COMPANY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE #: _____
INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____
ID #: _____ GROUP/POLICY: _____

ADDITIONAL INSURANCE

INSURANCE COMPANY NAME: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE #: _____
INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____
ID #: _____ GROUP/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 City of Schertz EMS WHETHER IN THE PAST, NOW OR IN THE FUTURE.**

PATIENT OR AUTHORIZED PERSON'S SIGNATURE

DATE

RELATIONSHIP TO PATIENT

**NOTICE: THIS FORM MUST BE COMPLETE AND SIGNED BEFORE WE CAN FILE
YOUR INSURANCE. IF THIS IS WORKER'S COMPENSATION CLAIM, PLEASE CALL
THE NUMBER ABOVE.**