HOLLIDAYSBURG AMERICAN LEGION AMBULANCE SERVICE

801 Scotch Valley Road, PO Box 461
Hollidaysburg, PA 16648
(814) 695-1421

INSURANCE INFORMATION FORM

Name ____
Last First Middle Initial

Address ____
Street City State Zip

Telephone ____________________ Date of Birth ________________ Social Security # ____________________

PLEASE COMPLETE BOTH PRIMARY AND SECONDARY INSURANCE

Medicare# ____________________ RR Medicare# ______________________Access# ____________________

Primary Insurance Co	Secondary Insurance Co
______________________________	______________________________
Insurance Company	Insurance Company
______________________________	______________________________
Address	Address
______________________________	______________________________
City/State/Zip	City/State/Zip
______________________________	______________________________
Telephone #	Telephone#
______________________________	______________________________
Policy Holder	Policy Holder
______________________________	______________________________
Agreement/Group Number	Agreement/Group Number

YOUR SIGNATURE IS REQUIRED

I authorize Hollidaysburg American Legion Ambulance Service (HALAS), to bill and receive payment from Medicare and/or other insurance carriers for any ambulance service I (we) may use. Services rendered that were not medically necessary will be subject to HALAS's current billing policy. I authorize any holder of medical information or documentation about me, to be released to Centers for Medicare & Medicaid Services, as well as HALAS, for the processing of any claim for services rendered. I permit a copy of this authorization to be used in place of the original.

I also acknowledge that I have received a copy of the Hollidaysburg American Legion Ambulance Service Notice of Privacy Practices.

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Patient or Responsible Party's Signature Date

To all insurance carriers: Please make payment directly to Hollidaysburg American Legion Ambulance Service for services rendered.