# Patient Health Insurance Information

**Please fax completed forms to: 402-625-0012**

Name on Account: _____

Date of Birth: _____

Invoice Number: _____

Date of Service: _____

***Ins. Name*** _____

***Ins. Address*** _____

***City/State/Zip*** _____ ***Phone #*** _____

***Name of Insured*** _____***Date of Birth*** _____

***Member #*** _____ ***Group#*** _____

***Medicare #*** _____ ***Medicaid #*** _____

**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS and RELATED RELEASE OF INFORMATION**

I request payment of authorized benefits directly to Midwest Midwest Medical Transport Company for services furnished to me by Midwest Medical Transport Company.

I also authorize the release of medical and other information related to such services to Medicare, Medicaid, my insurance company, HMO, or other third party payers, or their third party administrators, in order to process and pay claims, determine benefits and perform quality of care review.

I understand that I will be responsible for any services that are not paid/covered by my insurance. A Copy of this authorization shall be valid as the original.

**Signature** _____**Date**_____

Patient, or if Patient is unable to sign, a Representative of the Patient

Relationship_____ Reason Patient is Unable to Sign _____

Representative's Address_____