

EMPLOYMENT ACCIDENT INSURANCE FORM – City of Pullman Ambulance

Please complete this form and return it to City of Pullman Ambulance, 620 S Grand Ave, Pullman, WA 99163 within 7 days of the receipt of this notice. This form, as well as, other forms are available at www.pullman-wa.gov/fire/ambulanceforms

Patient's Legal Name: _____

City of Pullman Ambulance Acct #: Run _____ - _____ Date of Service: ____/____/____

Patient's Permanent Mailing Address: _____

City, ST, Zip Code: _____/_____/_____

Patient's Phone Number: _(____)_____ or_(____)_____ DOB: ____/____/____

SSN: _____-_____-_____ Student ID #: _____ Driver's License #: _____

* It is not mandatory to provide your Social Security Number. City of Pullman requests your Social Security Number pursuant to its authority under RCW 35A.11.020 and may use your Social Security Number for insurance claim processing and collection of past due accounts.

Email Address: _____

LABOR AND INDUSTRIES OR WORKER'S COMPENSATION CLAIM FORM:

Policy Holder (Business/Employer): _____

Claim Number: _____ Date of Injury: ____/____/____

Name of Insurance Plan: _____

Insurance Plan Address: _____

City, State, Zip Code: _____

SECONDARY INSURANCE: Please include a copy of your insurance card (front and back)

Insured Name (EXACTLY as it appears on the insurance card): _____

Patient's Relationship to Insured/Subscriber: Self / Spouse / Child / Other (If you are the dependent, please provide the following)

Subscriber's Name: _____ DOB: ____/____/____

Name of Insurance Company: _____

Insurance ID # (provide ALL prefix and suffix letters and numbers): _____

Insurance Group/Plan #: _____ Insurance Phone #: _(____)_____

Insurance Claims Address: _____

City, ST, Zip Code: _____

Please list any individuals you authorize to have access to your ambulance transport account financial information.

- 1) _____ Relationship: _____
- 2) _____ Relationship: _____

Privacy Practices Acknowledgement: By providing my signature, I acknowledge that I have received a copy of the City of Pullman Ambulance Notice of Privacy Practices.

Signature: _____ Date: _____ / _____ / _____

FINANCIAL ACCEPTANCE

Benefit Responsibility: I give City of Pullman Ambulance permission to bill my insurance or other entity providing benefits to me for the ambulance services provided to me now, in the past, or in the future, until I revoke this authorization in writing. My insurance has permission to pay City of Pullman Ambulance directly for any services billed. If I or any family member should receive payment for ambulance services provided by the city of Pullman Ambulance, I shall immediately forward such payment to City of Pullman Ambulance. I understand that I will be billed and am responsible for payment of any services.

Patient Signature: (Only)

_____ Date: _____ / _____ / _____
(A legal patient signature is that of an individual 18 years and older. Parent may NOT sign for an adult child)

Or, an Authorized Representative. A signature of someone other than the patient is only accepted in the event the patient is either mentally or physically incapable of signing due to injury or medical condition. (Unwillingness and unavailability to sign are not acceptable reasons)

Please specify a valid reason below: (Required)

The City of Pullman Ambulance has the right to refuse to submit a claim on behalf of the patient. The patient will then be responsible for filing a claim with their insurance company on their own accord.

Authorized Representative Signature:

_____ Date: _____ / _____ / _____
(Spouse, Legal Guardian, Relative, or Power of Attorney; include copy)

Printed Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ / _____
Phone #: ____ (____) _____ DOB: _____ / _____ / _____

PATIENT RESPONSIBILITY

Claim Processing: Insurance claim filing is done as a courtesy. The City of Pullman Ambulance Billing Office will submit a claim on behalf of the patient to the patient's insurance company. It is the responsibility of the patient to provide the Ambulance Billing Office with an accurate billing address, current insurance information and a signature. If this information is not provided within a timely manner of received services, claim submission will become the responsibility of the patient. The patient will be required to pay all charges and associated penalties.

If the claim is denied after the second attempt for insufficient or inaccurate information: City of Pullman Ambulance has the right to refuse to bill an insurance company after two failed attempts. If this occurs, the patient is required to pay their account balance in full upon receipt of invoice. It will then become the patient's responsibility to submit his/her own claim and resolve the matter with their insurance company for the ambulance service. The patient will need to complete a Records Request form which can be obtained from the Ambulance Billing Office. This information will be needed in order to file their claim.

Payments: The balance of your account is due when the invoice is issued, and is considered past due if not paid in full at the end of thirty (30) days. City of Pullman Ambulance does not offer charity nor a reduction in ambulance fees.

You may choose to pay your account balance one of three ways:

- 1) Check or Money Order – Send Payment to: City of Pullman; 325 SE Paradise St. Pullman, WA 99163 (Please include your Ambulance Run# with your payment)
- 2) Cash – Pay in person: Finance Department; 325 SE Paradise St. Pullman, WA 99163
- 3) Credit Card or Debit Card – Payments can only be made through the City of Pullman website at www.pullman-wa.gov . If using a credit or debit card, you will be charged an additional fee by a third party company to process your payment.

Note: The City will charge a fee for a returned check. The fee is currently \$15.00 for any checks returned by a bank.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. The Ambulance Billing Office will mail two (2) invoices and one (1) Pre-Collection Letter advising you of your account status before the account is turned over to Full-Collections. The City has partnered with Automated Accounts, Inc. out of Spokane, WA for collection matters.

Waiver of Confidentiality: Please understand if this account is submitted to a collection agency, or if you're past due status is reported to a credit reporting agency, the fact that you received an ambulance transport may become a matter of public record.

Separation/Divorce: In the case of a legal separation, the party(s) responsible for the account prior to the legal separation remain(s) responsible for the account. After a divorce or legal separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires one or the other parent to pay all or part of the service costs, it is the authorizing parent's responsibility to collect from the other parent.

Minor Children vs. Adult Children: If the child is under the age of 18 at the time of medical service, the balance of the child's account is the responsibility of the authorizing custodial parent. If the minor patient turns 18 and a balance is still owed, the balance owing on the account then becomes the responsibility of both the patient and the Legal Guardian(s). If the patient/adult child is over the age of 18 years at the time of service, he/she will be responsible for any and all ambulance transport expenses incurred by them. That debt and subsequent charges will be subject to collection fees and credit reporting practices if it remains unpaid.

Medical Records Request: You will need to request a Medical Records Release form from the Pullman Ambulance Billing Office. There is a charge per page. Please refer to the City's website at www.pullman-wa.gov for the most current copy fee schedule. Copy fees are required in advance of the city mailing your requested information. Fees are accepted in the form of cash, check or money order. The amount of this fee will depend on how many pages there are to copy. Payments should be made directly to the City of Pullman Ambulance Department at 620 S Grand Ave., Pullman, WA 99163.

Notice of Privacy Practices: The City of Pullman Ambulance Department is committed to protecting your personal health information. Your health information cannot be used or shared without your written permission unless the law allows. We are also required by law to provide you with a Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your PHI.