CARE
AMBULANCE SERVICE, INC.
1517 W. Braden Court, Orange, CA 92868
Phone: (714) 288-3834 | Fax: (714) 288-3891

Patient Name:

Patient Address:

Ticket Number:

Date of Service:

Please fill out this letter, sign, and return via mail or fax.

Our records indicate that you were involved in an auto accident. To ensure reimbursement is obtained from the proper payer/insurance agency, we will need your assistance in completing the following information. In an effort to allow us to process your claim as quickly as possible, it would be appreciated if you could have this returned to our office on or before the due date indicated below.

Select One and please provide the needed info for us to correctly bill.

1._____ I have "Medical Payment" coverage under my auto Insurance policy and would like Care Ambulance to send the bill to them:

Insurance Agency: _____ Claim #_____

Adjustor Name: _____ Adjustors Contact #: _____

2._____ I DO NOT have "Medical Payment" coverage under my auto insurance policy; therefore I wish to have my private health insurance billed. (Please remember: If you have medical coverage under your auto policy please be advised that your auto insurance would then be primary and your health insurance should not be billed.)* Please also attach a copy of health insurance cards*****

Insurance: _____ ID #: _____

Group Number: _____ Effective date: _____

3._____ I have OR in the event that I will obtain an Attorney: I do not wish to have my Auto insurance or Private Health Insurance billed. I understand that Care Ambulance does not wait for my case to settle nor do they accept liens and the bill will be my responsibility. As a courtesy Care Ambulance will provide me with payment options, if payment in full cannot be made. Please note: If Care Ambulance is notified that payment in full has been forwarded directly to an attorney or myself, payment in full will be forwarded to Care Ambulance.

If this letter is not returned within 30 days of the date on this letter, your account will fall under our patient billing process and you will receive a statement.

Signature of Patient / Legal Guardian _____

In the event that we need further information, please provide us with a phone number where you can be contacted.

Phone number ( ) ____ - _____

Please contact our office with any questions at 714-288-3834

Si usted necesita hablar con alguien en español sobre a que esta carta se refiere, por favor póngase en contacto con nuestra oficina al 714-288-3834

Thank you