BKP AMBULANCE DISTRICT
439 S. MAIN ST
KENTON, OH 43326-1946
419-674-4574

BKP
AMBULANCE DISTRICT
KENTON-HARDIN CO.
ADVANCED LIFE SUPPORT

Patients Name:
Patient Id:
Run Number:
Date of Service:
Ticket Balance:

Dear Customer:

We do not have the necessary insurance information to allow us to file the claim for you. If you would like us to file the claim, please provide us with the necessary information required to the file the claim.

PLEASE COMPLETE THE ENTIRE FORM.
IF THIS IS FOR AN AUTO ACCIDENT, PLEASE LIST AUTO INSURANCE AS THE PRIMARY INSURANCE

Social Security Number: _____ Date of Birth:_____

Primary Insurance: _____

Member ID/Policy # _____Phone #_____

Insurance Address:_____

City:_____State:_____Zip:_____

Insured Name:_____Insured Date of Birth: _____

Secondary Insurance: _____

Member ID/Policy # _____Phone #_____

Insurance Address:_____

City:_____State:_____Zip:_____

Insured Name:_____Insured Date of Birth: _____

In consideration of service rendered by the above named department, I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me now, in the past, or in the future, until such time as I revoke this authorization in writing. I agree to pay for said service if payment is not made by my insurance. I permit a copy of this authorization to be used in place of the original and request payment of benefits be made directly to the provider. Medicare will only pay for services that it determines are reasonable and necessary. Medicare will deny payment for non-emergency and/or elective ambulance services. If Medicare does deny payment for this claim, I agree to pay for such services.

Signature_____Date_____