PARAMEDIC BILLING OFFICE
P.O. BOX 18157
ST. PAUL, MN 55118
Phone (651) 450-7133
Fax (651) 450-7128

INSURANCE REQUEST FORM

To better assist us with billing your insurance, please provide the following information. Please print out this form with any available information, fill it out, and fax or mail it back to us using the address above. Thank you.

Date of Incident: ______________________________

Patient Account Number/Name: ______________________________

Health Insurance Company Name: ______________________________

Health Insurance ID Number: ______________________________

Health Insurance Group Number: ______________________________

Health Insurance Address (if out of network applies, please provide that address):

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Health Insurance Phone Number: ______________________________

Secondary Insurance Name: ______________________________

Secondary Insurance Number: ______________________________

Secondary Insurance Address (if out of network applies, please provide that address):

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Secondary Insurance Phone Number: ______________________________

Workers Compensation Claim Number (if applicable): ______________________________

Automobile Insurance Claim Number (if applicable): ______________________________