PLATTE VALLEY AMBULANCE SERVICE LLC
PO Box 90
Danville, PA 17821-0090
ADDRESS SERVICE REQUESTED

December 14, 2023

4 588240900

THEODORE J ANGEL
6002 Grape Dr
Commerce City CO 80022-3220

0013 001999

1 of 1

REMIT TO:
Platte Valley Ambulance Service LLC
PO Box 90
Danville, PA 17821-0090

PATIENT NAME			BALANCE
THEODORE J ANGEL			$0.00
RUN NUMBER	DATE OF SERVICE	STATEMENT DATE	AMOUNT ENCLOSED
23-22603	02/23/2023	12/14/2023	$

REQUEST FOR INSURANCE AND AUTHORIZATION

Dear THEODORE J ANGEL,

Our records indicate you were treated by Platte Valley Ambulance Service LLC and transported by ambulance on the above date. We do not have on record any information to forward this claim to your insurance provider on your behalf. Please fill out this form and return AS SOON AS POSSIBLE, so we may forward this claim to your insurance provider.

If you do not have insurance, the balance due is your responsibility and must be paid in full upon receipt of this form.

We trust our service was helpful in your time of need, and we hope your recovery has progressed well. If you have any questions, need help in completing this form, or would rather just call us with your insurance information, please call (888) 505-5166.

Primary Health Insurance

Ins. Name:_____
Address:_____
City/State/Zip:_____
Phone#:_____
Subscriber ID#:_____
Group #:_____
Date of Birth:_____

Secondary Health Insurance

Ins. Name:_____
Address:_____
City/State/Zip:_____
Phone#:_____
Subscriber ID#:_____
Group #:_____
Date of Birth:_____

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to Platte Valley Ambulance Service LLC for any services furnished me by that health service supplier now, in the past, or in the future. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents or other insurance companies any information needed to determine these benefits or the benefits payable for related services now, in the past, or in the future.

I also assign Platte Valley Ambulance Service LLC the right to appeal all claims determinations or denials on my behalf. I understand that I am financially responsible for the services rendered by Platte Valley Ambulance Service LLC and agree to immediately remit all payment I receive from my insurance or other benefits provider to Platte Valley Ambulance Service LLC. A copy of this authorization is as valid as the original.

SIGNATURE: _____ DATE: _____

(If the patient is unable to sign, state medical or physical reason why) Reason why patient can not sign: _____

RELATIONSHIP TO PATIENT: (if unable to sign) _____
(I understand if I am signing on behalf of the patient, that I am not financially responsible for payment)

PPQUIC024

You can also complete and or update your information online at:
Online at > www.quickmedclaims.com
Click on Patient Access Portal
Company Code: D414

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PLEASE COMPLETE THE INFORMATION ABOVE AND RETURN THIS ENTIRE FORM IN THE ENVELOPE PROVIDED. **REMEMBER TO SIGN AND DATE AT THE BOTTOM.**