Toll-free: 1 (866) 245-4373
Fax: 1 (888) 489-8991
www.airliftnw.org

QUICKMED CLAIMS
PO Box 18210
Pittsburgh PA 15236-0210

> > > > PLEASE FOLD ALONG DOTTED LINE, AND RETURN THIS ENTIRE FORM IN THE ENVELOPE PROVIDED < < < <

REQUEST FOR INSURANCE and AUTHORIZATION

Dear _____:

Our records indicate you were treated by _____ and transported by air 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:

Primary Health Insurance	**Secondary Health Insurance**
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone #: _____	Phone #: _____
Subscriber ID #: _____	Subscriber ID #: _____
Group #: _____	Group #: _____
Date of Birth: _____	Date of Birth: _____

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to _____ for any services furnished me by that health service supplier. 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.

I also assign _____ the right to appeal all claims determinations or denials on my behalf. I understand that I am financially responsible for the services rendered by _____ and agree to **immediately remit all payment I receive from my insurance or other benefits provider** to _____. 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) _____

RPPQUIC01A3 (I understand if I am signing on behalf of the patient, that I **am not** financially responsible for payment)

↑ Please complete the information above and return this entire form in the envelope provided. ***Remember to sign and date at the bottom.*** ↑