DCFEMS PATIENT IDENTITY DISPUTE FORM

RETURN MAIL TO:

DC Fire and EMS Department
P.O. Box 27767
Washington, DC 20038

Account Number:

Date of Service:

Thank you for submitting a patient identity dispute request to DCFEMS. When submitting a patient identity dispute request, DCFEMS requires that a person or party representing the person accurately provide all the following information. A supplemental letter, with further explanation, may also be attached.

_____ _____
Person's Full (Legal) Name **Person's Birth Date**

_____ _____
Person's Full Residential Address (Apt#, City, State) **Zip Code**

_____ _____ _____
Person's Contact Telephone **Person's Representative (If Applicable)** **Representative Contact Telephone**

PLEASE INDICATE ALL THAT APPLY:

YES ☐	The person misidentified as the patient was not transported by ambulance on the date indicated (please attach supplemental documentation, if needed).
YES ☐	The person misidentified as the patient was not living in, working in, or visiting the District of Columbia on the date indicated (please attach supplemental documentation, if needed).
YES ☐	I am not the patient identified by the account number, date of service, or other information provided to me by the DCFEMS third party billing service.
YES ☐	Other reason (please include supplemental letter and/or explain below):

By signing this form, I am requesting that DCFEMS verify my personal identifying information and consider waiving the ambulance fees and charges which were incorrectly billed to me for the reasons stated above. I understand that I may be required to provide documentation supporting this request, if asked. By signing this form I certify, under applicable penalties of law, that all of the above is accurate to the best of my knowledge and that I am not misrepresenting any of the information provided.

_____ _____
Signature of Patient or Patient Representative **Date**

Need Help? Please Call 1-202-673-3368