DCFEMS INSURANCE REVIEW FORM

RETURN MAIL TO:

DC Fire and EMS Department
P.O. Box 717767
Philadelphia, PA 19171-7767

Account Number:

Date of Service:

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

______________________________	______________
Patient Full (Legal) Name	**Patient Birth Date**
Patient Full Residential Address (Apt#, City, State)	**Zip Code**

______________	______________	______________
Patient Contact Telephone	**Patient Representative (If Applicable)**	**Representative Contact Telephone**

PLEASE INDICATE ALL THAT APPLY:

YES ☐	The patient was not identified as having insurance on the date of ambulance transport, but submitted insurance coverage information, and the claim filing deadline has expired.
YES ☐	The patient experienced an insurance claim processing error resulting in claim rejection or denial, and the claim re-filing deadline has expired.
YES ☐	The patient experienced insurance claim denial, or the insurer did not respond to the claim, and the claim was re-filed without further action by the insurer or another insurer.
YES ☐	The patient experienced a high out-of-pocket unpaid balance ($500 or more), and such a balance was the result of an insurer applied deductible and/or co-pay.
YES ☐	The patient experienced involuntary ambulance transport, and an insurer denied or did not respond to the claim.
YES ☐	Other reason (please include supplemental letter and explain).

By signing this form, I am requesting that DCFEMS consider reducing my ambulance fees and charges for reasons of insurance review. 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