HAMPTON DIVISION OF FIRE AND RESCUE
P. O. BOX 3192
HAMPTON VA 23663–0192

Account Information

Account Number:
Statement Date: 03/07/17
Due Date: 03/28/17
Amount Due: $125.00

Patient Statement

This bill is for emergency ambulance service provided by Hampton Division of Fire and Rescue. If you wish to make payment arrangements please call 1–877–967–6333. The balance due after insurance coverage is your responsibility, kindly remit payment. If you have updated insurance information please contact us and we will file a new claim on your behalf.

Date	Description	Patient	Charges	Payments & Adjustments	Insurance Balance	Patient Balance
03/02/17	AMBULANCE RESPONSE/ TREATMENT 001		125.00			
	Service Summary 03/02/17		125.00			125.00

Total Patient Balance: $125.00

FOR PAYMENT AND BILLING QUESTIONS
Phone: 1–877–967–6333
Business Hours: Monday – Friday, 8:00 AM and 5:00 PM EST

IF PAYING BY MAIL, PLEASE DETACH AND RETURN BOTTOM PORTION WITH YOUR PAYMENT.

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I authorize the submission of a claim for payment to Medicare, Medicaid , or any other payor who accepts assignment for any services provided to me by **Hampton Division of Fire and Rescue** now, in the past or in the future.

Signature__________________________Date________

Account Number	Statement Date	Due Date	Amount Due
	03/07/17	03/28/17	$125.00

☐ Please check box if address is incorrect or insurance information has changed, and indicate change(s) on the back of this form.

PLEASE WRITE YOUR ACCOUNT NUMBER ON CHECK

AMOUNT ENCLOSED $

Thank you!

PLEASE MAKE CHECKS PAYABLE TO AND MAIL TO:

01–C 20170308 P138 S 00131

HAMPTON DIVISION OF FIRE AND RESCUE
PO BOX 3192
HAMPTON VA 23663–0192

Please use the boxes below to update any information that may have changed since your last statement.

ABOUT YOU

YOUR NAME (Last/First Middle Initial)	TELEPHONE		
STREET ADDRESS	CITY	STATE	ZIP
EMPLOYER'S NAME	TELEPHONE		
EMPLOYER'S STREET ADDRESS	CITY	STATE	ZIP

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

ABOUT YOUR INSURANCE

PRIMARY INSURANCE COMPANY - SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE		
YOUR PRIMARY INSURANCE COMPANY	ID#	GROUP#	
PRIMARY INSURANCE COMPANY'S ADDRESS	CITY	STATE	ZIP
SECONDARY INSURANCE COMPANY - SUBSCRIBER NAME	SUBSCRIBER BIRTH DATE		
YOUR SECONDARY INSURANCE COMPANY	ID#	GROUP#	
SECONDARY INSURANCE COMPANY'S ADDRESS	CITY	STATE	ZIP

X-602 20120907