LIFE FLIGHT NETWORK
PO Box 3881
Seattle WA 98124-3881

ADDRESS SERVICE REQUESTED

REMIT TO:

February 19, 2019

LIFE FLIGHT NETWORK
PO BOX 3881
Seattle WA 98124-3881

«LetterCode» «IMBSerialNumber»

«FullName»
«AttnLine»
«Address1»
«Address2»
«City» «State» «ZipCode»-«ZipPlus4»

You can also complete and or update your information online at:
Online at ➢ www.lifeflight.org/billing
Click on (Patient Access or Bill Pay)
Company Code: «ClientInsert1»

BALANCE	DATE OF SERVICE	STATEMENT DATE
$«Insert16»	«Insert27»	02/19/2019

Please Read and Sign Below

INSURANCE AUTHORIZATION

I request that payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to «INSERT2» 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 «INSERT2» the right to appeal all claims determinations or denials on my behalf. I understand that I am financially responsible for the services rendered by «INSERT2» and agree to **immediately remit all payment I receive from my insurance or other benefits provider** to «INSERT2». 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 cannot 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)

1PPQUIC01LFN3

REQUEST FOR INSURANCE and SIGNATURE AUTHORIZATION

Dear «FullName»,

Our records indicate you were treated by «INSERT2» 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.

Unless other arrangements are made, payment is due within 30 days of receipt of invoice.

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: 1-866-883-9998.

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: _____

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