City of Houston
Emergency Medical Services

PO Box 4945
Houston, Texas 77210-4945
713-963-0732 (Phone)
1-800-929-6209 (Toll Free)
1-888-fax-ems9 (Toll Free Fax)

Insurance Submittal Form

Use this form to submit your insurance documentation so that we may bill your insurance company. We accept medical insurance, Medicare and Medicaid. Please complete each field and then mail this form to the above address or fax toll free to 1-888-fax-ems9. If possible, include a front and back copy of your insurance card. You may also call us and submit your information over the phone.

_____ _____
Account Number From Bill | Patient Social Security Number

_____ _____ _____
Patient First Name | Patient Middle Name | Patient Last Name

_____ _____ _____ _____
Patient Address | City | State | Zip

(_____)_____ (_____)_____ _____
Home Phone | Work Phone | Email Address

Parent/Guardian or Responsible Party Name:_____ _____
First, Middle, Last | Phone, if different than above

If you have Medical Insurance: *(Include a front and back copy of your insurance card if possible)*

_____ _____
Insurance Company Name | Insurance Company Address City State Zip

(_____)_____ _____ _____
Insurance Phone Number | Insurance Policy Number | Insurance Group Name & Group Number

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If You Have Medicare:

_____
Medicare Beneficiary Number

If You Have Medicaid:

_____
Medicaid Recipient Number

Release of Information and Payment Authorization

I certify that the information given in applying for payment under Title XVIII of the Social Security Act or insurance information is correct. In compliance with the Health Insurance Portability & Accountability Act, I authorize release of all medical records required to act on this request and I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the City of Houston.

Signature: _____ Date: _____