Camille Care Solutions Ambulette Service LLC

INSURANCE & BILLING INFORMATION SHEET

Please.complete.all.applicable.fields.and.provide.copies.of.insurance.cards.and.required.authorization.documents¡.Information.is.used.to.verify.benefits?obtain.authorization?and.submit.claims¡

Patient & Service Information

Date Completed: _____	**Requested Service Date:** _____	
Patient/Member Full Name: _____	**Date of Birth:** _____	**Phone:** _____
Home Address: _____		
City: _____	**State:** _____	**ZIP:** _____
Responsible Party/Guardian: _____	**Relationship & Phone:** _____	

Primary Insurance Information

Insurance Company/Plan: _____	**Plan Type:** ☐ Medicaid ☐ Medicare ☐ MCO ☐ Commercial ☐ Other	
Member/Policy ID: _____	**Group Number:** _____	
Subscriber Name: _____	**Subscriber DOB:** _____	**Relationship:** _____
Insurance Phone: _____	**Claims Address:** _____	
Transportation Broker/Transportation Manager (if applicable): _____		

Secondary Insurance & Authorization

Secondary Insurance Company: _____		**Member/Policy ID:** _____	**Group Number:** _____
Prior Authorization Required? ☐ **Yes** ☐ **No** ☐ **Unknown**		**Authorization Number:** _____	
Authorized Trips/Units: _____	**Effective Date:** _____	**Expiration Date:** _____	**Copay/Coinsurance:** $_____
Authorization Contact/Representative: _____		**Reference/Call Number:** _____	

Transportation & Billing Details

Pickup Location: _____	**Destination/Facility:** _____
Purpose of Trip/Appointment Type: _____	
Mobility/Assistance: ☐ **Ambulatory** ☐ **Wheelchair** ☐ **Walker/Cane** ☐ **Escort**	**Trip Type:** ☐ One Way ☐ Round Trip ☐ Recurring
Referring Provider/Facility: _____	**Provider NPI/Phone:** _____

Billing Contact Name: _____	Billing Contact Phone/Email: _____
Special Billing Instructions/Notes: _____ _____	

Certification & Office Use		
I certify that the information provided is accurate to the best of my knowledge. I authorize Camille Care Solutions Ambulette Service LLC to verify coverage and submit claims for services rendered. This form is not a guarantee of payment; the patient/member or responsible party may be responsible for non-covered services, deductibles, copays, or coinsurance.		
Patient/Responsible Party Signature: _____	Date: _____	
Verified By: _____	Verification Date: _____	Claim/Trip Number: _____
Office Notes: _____		