Lower Cape Ambulance Association

FINANCIAL INFORMATION
PAYMENT ARRANGEMENT/WRITE-OFF REQUEST
PLEASE COMPLETE ALL SECTIONS

A: Patient Name:_____Telephone #:_____
Current Mailing Address:_____

B: I am seeking to make payments of $ _____
Please circle one:
WEEKLY MONTHLY OTHER

_____ _____
Signature Date

We accept MC/Visa for payment:

_____ _____ _____
Name on Card Card Number/Type Exp. date

C: Request for write-off/reduction in bill

1. Employer:_____ Telephone #:_____
2. Name of person responsible for bills: _____
3. Address: _____ Telephone #:_____
4. List ALL MEDICAL INSURANCE in effect on the date of service.
   Please provide subscriber number and cert numbers, (ie: Blue Cross, Medicare, Medicaid, Etc)
   _____
5. Was the emergency ambulance service the result of a work related accident or an auto accident for which another person/insurance might be responsible?
   Please supply as much information as possible:

_____
_____

D: Sources of income (Monthly Gross)

1. Total family income for last three (3) months $_____
2. Total family income for last twelve (12) months $_____
3. Number of dependents including yourself: _____

This information will be used to determine the necessary payment according to the Hill Burton Regulations. These regulations, adopted by the Lower Cape Ambulance Association, establish income levels below which no payment will be required.

E: Certification

I understand, certify that the above facts are true and realize that any false statements or information will void any wrote-off approved by the Lower Cape Ambulance Association. I understand that my eligibility for write-off of this bill will be subject to supplying information to verify any of the above statements.

_____ _____
Signature Date

Please return form to:
Lower Cape Ambulance Association
PO Box 1721
Provincetown, Ma 02657