Air Methods®

Air Medical Transport Services provided by Air Methods Corporation

DEFENDERS OF TOMORROW™

Insurance Questionnaire

Please fill out all fields and return in the enclosed postage paid envelope. For help on filling out the form, contact us at:

(855) 896-9067

patientforms@airmethods.com

PATIENT NAME: _____ REFERENCE #: _____

MEDICARE #: _____ PART B EFF. DATE: _____ DATE OF BIRTH: ____ / ____ / _____

MEDICAID ID #:_____ ELIGIBILITY DATE: _____ DATE OF BIRTH: ____ / ____ / _____

PRIMARY HEALTH INSURANCE INFORMATION

Company Name:_____ Phone:_____

Claim Address:_____ City:_____ St:_____ Zip: _____

Date of Birth: _____ / _____ / _____

I.D.#: _____ Group #: _____ Name of Insured: _____

SECONDARY HEALTH INSURANCE INFORMATION

Company Name: _____ Phone:_____

Claim Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ / _____ / _____

I.D.#: _____ Group #: _____ Name of Insured: _____

WAS THIS WORK RELATED? *Yes* ☐ *No* ☐ *, if yes, please provide:* Date of Injury _____ / _____ / _____

Employer:_____ Phone: _____

Address:_____ City: _____ St:_____ Zip:_____

Work Comp Carrier Name:_____

Phone: _____

Address:_____City:_____ St:_____ Zip:_____

Adjuster's Name: _____ Claim Number: _____

WAS THIS AN AUTO ACCIDENT? *Yes* ☐ *No* ☐ *, if yes, please provide your auto insurance information:*

Auto Ins. Company:_____ Phone:_____

Address:_____ City: _____ St:_____ Zip:_____

Insured's Name: _____ Adjuster Name: _____ Claim #: _____