About your bill

The City of West Des Moines Emergency Medical Services fees are based upon the services provided, mileage, medications and supplies used in the delivery of pre-hospital care by our EMTs and Paramedics. You, as the patient are responsible for full payment for services provided. Full payment of your account is requested within 30 days.

If payment in full is not feasible or you have questions about your bill, call our billing office Monday-Friday between 8:00 a.m. and 4:30 p.m. at 515-222-3652.

Medicare Patients

As required by law we will file your Medicare claim for you. We must however have a signed authorization from you allowing us to release the appropriate information regarding your care and treatment to Medicare and authorizing them to make payment. In order for us to file your claim, you will need to complete the following information. If you have a supplemental insurance policy please be sure to indicate that below. **Be sure to sign the authorization located on the back of this information sheet and return this form to our office.**

Write your Medicare number here: :

Medicaid Patients

The City of West Des Moines Emergency Medical Services participates with the State of Iowa Medicaid program. In order for us to file your claim, you will need to complete the following information. **Be sure to sign the authorization located on the back of this information sheet and return this form to our office.**

Write your Medicaid number here: :

Private/Supplemental Insurance

Our office will file your private insurance claim for you, *if not automobile related*, on your behalf when you provide us with a copy of both sides of your insurance card or complete the information requested below. **Be sure to sign the authorization located on the back of this information sheet and return this form to our office.**

INSURANCE COMPANY NAME:		
CLAIMS OFFICE MAILING ADDRESS	**POLICY NUMBER**	**GROUP NUMBER**
	NAME OF POLICY HOLDER	**RELATIONSHIP TO PATIENT**

– OVER –

y Authorization to file for insurance benefits:

I request payment of authorized Medicare and/or insurance benefits be made either to me or on my behalf to the City of West Des Moines Emergency Medical Services, for any services furnished to me. I authorize any holder of hospital or medical information about me to be released to the City of West Des Moines Emergency Medical Services, the Health Care Financing Administration and/or my insurance carrier, and their agents, any other information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand this authorization may be used by the West Des Moines Emergency Medical Services for all services in the future until such time I revoke this authorization in writing.

Sign here **X** _____ _____

PATIENT SIGNATURE DATE

Please PRINT patient name:	
WDMEMS Patient Number: (from bill)	WDMEMS Call Number: (from bill)

L Private Pay, No Insurance Benefits:

For your convenience we accept checks, VISA or MasterCard. If you wish to pay by credit card please complete the information below.

Write your credit card information below:

– – –

Card Expiration Date: | | | – | | |

Cardholder acknowledges receipt of services and agrees to perform the obligations set forth in the Cardholder's agreement with the issuer.	Cardholder Signature:

We understand that some of our clients are suffering from financial hardships and may have a difficult time paying for services rendered to them in one lump sum payment. If payment in full is not feasible or you have questions about your bill, call our billing office Monday-Friday between 8:00 a.m. and 4:30 p.m. at 515-222-3652 to discuss payment arrangements.

Questions: 515-222-3652

3421 Ashworth Road, PO Box 65320 - West Des Moines - Iowa - 50265