

CITY OF HOLLYWOOD FIRE RESCUE REQUEST FOR AMBULANCE FEE WAIVER/REDUCTION FORM



INSTRUCTION: This form must be submitted for EACH ambulance transport incident billed. Provide documentation of monthly household income. **ACCEPTED DOCUMENTS:** Current pay stub, bank statement, previous year's tax return, social security statement, unemployment commission letter, homeless shelter letter, letter of explanation for patients with no income. **NOTE:** If there is a balance due, a payment plan can be considered. **Mail:** 2741 Stirling Road, Hollywood, FL 33312-6505.

APPLICANT NAME: _____

ADDRESS: _____

TELEPHONE: (W) _____ (C) _____ (H) _____

**MONTHLY HOUSEHOLD GROSS INCOME FOR ALL ADULTS WHO WORK AND SHARE INCOME AND EXPENSES IN YOUR HOUSEHOLD: \$ _____ TOTAL OF PERSONS IN HOUSEHOLD: _____

I am requesting the City of Hollywood Fire Rescue to **waive** the ambulance transport fee in the amount of \$ _____ for invoice number _____ for Date of Service _____.

I am requesting the City of Hollywood Fire Rescue to **provide a monthly payment plan** for the balance of the ambulance transport fee in the amount of \$ _____ for invoice number _____ for Date of Service _____.

I certify that I have no additional means of payment or no means of payment for by which the ambulance transport fee can be settled.

Signature

Printed Name

Date

DO NOT FILL OUT BELOW THE LINE IT IS FOR ADMINISTRATIVE USE ONLY

ANNUAL GROSS INCOME: \$ _____ Change Healthcare Invoice No.: _____

Primary Insurance Payment Amount: \$ _____ Secondary Insurance Payment Amount: \$ _____

Revised Amount Due: \$ _____ Amount Waived: \$ _____

DENIED CLAIM DATE: _____ CHANGE HEALTHCARE ADVISED DATE: _____

APPROVED FOR WAIVER OR REDUCTION SIGNATURE: _____ DATE: _____