COASTAL HEALTH SYSTEMS OF BREVARD, INC.

Dispatch Phone # (321) 631-1448 ~ Dispatch Fax # (321) 633-8501

PATIENT DEMOGRAPHICS and INSURANCE INFORMATION FORM

For the use of facilities that do not provide face sheets.

This form is required to accompany the Interfacility Ambulance Transport Request when a facility face sheet is not provided

1. Date of Service **Appt/Discharge Time:** **Return Time:** ☐ **Check if One Way**

2. Patient: LAST **FIRST** **MI** **PT SS#**

PT SEX: **PT DOB**

3. Patient's Address:

City: **Zip Code:** **Telephone:**

4. INSURANCE INFORMATION:

☐ MEDICARE# _____

☐ MEDICAID# _____

☐ INSURANCE NAME _____ POLICY# _____

☐ PRIVATE PAY: _____

Guarantor name and phone number above.

6. Requesting facility contact: Phone# Fax#

EST 08/10