Application for Financial Assistance

PO Box 2084, Englewood, CO 80150
Phone (720) 459-8460 Fax (888) 422-9675
Email – billing@icareambulance.com
www.icareambulance.com

This form is used by our billing staff to evaluate options if you are unable to pay a portion or all of your ambulance bill. Please complete the information below to the best of your ability. Once this form is received by our office, a member of our staff will review it and contact you with all options available to you. If you need assistance, please contact our billing office at (720) 459-8460. **Please Email, Mail OR Fax completed form to iCare Ambulance.**

Name of person completing form	Phone#	Today's Date
Name of patient	Relationship to patient (circle one) **Self Spouse Child Parent Other**	
Run #	Date of Service	Amount of Bill
I am requesting: (check one) ◯ **Reduction of amount due** ◯ **Payment Plan** ◯ **Write-off of entire amount**		

Please provide a short explanation as to why you are unable to pay your bill in full:

I understand that this application is made so that iCare Ambulance can determine my eligibility for uncompensated services based on the established criteria of iCare Ambulance. If any information I have given proves to be untrue, I understand that iCare Ambulance may re-evaluate my financial status and take whatever action is deemed appropriate to recoup the ambulance charges owed.

I certify that the information provide here is true and accurate to the best of my knowledge. I further attest that payment would create a hardship for me and I request a waiver of the ambulance service fee. Further, I will make application for any assistance (Medicare, Medical Assistance, Etc) which may be available for payment of my bill and I will assign or pay to iCare Ambulance the amount recovered toward the ambulance bill.

_____
Signature of applicant