

EMERGENCY MEDICAL SERVICES INVOICE & RECEIPT

Receipt No.	
Date	
Incident No.	

PATIENT INFORMATION

Full Name

Date of Birth

Address

Contact No.

INSURANCE INFORMATION

Provider

Policy ID

Group No.

Auth Code

INCIDENT & TRANSPORT DETAILS

Date of Service

Dispatch Time

Pick-up Location

Service Type

Response Level

Destination

ITEMIZED CHARGES

Code	Description of Service / Supplies	Qty	Unit Price	Total Price

Subtotal

Insurance Paid

Patient Co-Pay

Balance Due

Patient / Responsible Party Signature

Authorized EMT / Paramedic

Authorized EMI / Representative
