

# County of King and Queen

## EMS Billing Program

### REQUEST FOR EMS BILLING HARDSHIP WAIVER

**NOTE: A NEW HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT**

Date of EMS Service: \_\_\_\_\_ Billing Reference Number: \_\_\_\_\_

#### Patient Information:

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Address (include City, State, and Zip) \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### Responsible Party (if different from patient)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Address \_\_\_\_\_

(include City, State, and Zip) \_\_\_\_\_

Phone: \_\_\_\_\_

Monthly GROSS HOUSEHOLD INCOME: \$ \_\_\_\_\_ Household Size (# of people) \_\_\_\_\_

I have attached the following documentation to certify that the above referenced gross income is true and accurate and provided proof of residency: **(Please check all that apply)**

**IF King and Queen County Resident, submit Proof of County Residency (example- copy of tax bill/property parcel #)** \_\_\_\_\_

Paycheck Stub (within past 60 days) \_\_\_\_\_

Primary Bank Statement (within past 60 days) \_\_\_\_\_

Tax Forms (most recent federal filed year) \_\_\_\_\_

Other: \_\_\_\_\_

I hereby request the County of King and Queen that I, as applicant or responsible party for the above name patient, be considered for a reduction in my payment responsibility. I certify that I have no insurance that can be billed for this charge, that the above information is true and correct to the best of my knowledge and I will be held responsible if false statements are made. I also agree to notify the County of King and Queen if my situation changes and the reduction is no longer necessary.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Mail this application and all attachments to:

King and Queen County EMS Billing  
c/o NNPDC Emergency Ambulance Service Revenue Recovery  
P.O. Box 70  
Warsaw, Va 22572

#### Administrative Use Only

Incident # \_\_\_\_\_ Invoice # \_\_\_\_\_ Date of Service \_\_\_\_\_

Date Received \_\_\_\_\_ Claim Status: APPROVED DENIED WAIVED Remarks: \_\_\_\_\_

Approval Signature: \_\_\_\_\_ Date \_\_\_\_\_