Ambulance Billing
Los Angeles Fire Department
P.O. Box 845257
Los Angeles, CA 90084-5257
(888) 772-3203

REQUEST FOR EMS BILLING CORRECTION OR EXEMPTION

(Official Use Only)
RECEIVED ON:

PATIENT AND ACCOUNT INFORMATION (Required)

Full Name (First, Middle, and Last Name) _____

Street Address _____ Apt. # _____

City _____ State _____ ZIP Code _____

Date of Service _____ Account Number _____

Daytime Phone _____ Alternative Phone _____

Email (if any) _____ Employee ID (if applicable) _____

***** PLEASE BE ADVISED THAT THIS FORM WILL NOT BE PROCESSED IF THE ABOVE INFORMATION IS MISSING OR INCOMPLETE. *****

ADJUSTMENT REQUESTED

Please select the appropriate box below and provide the required documentation.

1) ☐ **Billing Correction:** *A request for adjustment due to a clerical error or minor oversight.*

Requirements: Explain below and attach any supporting documentation. Use additional pages, if necessary.

2) ☐ **Hospital Unable to Provide Care:** *Pursuant to Los Angeles Administrative Code Section 22.210.2(f), a request for exemption by patients who have been transported by a private ambulance to a second hospital as a result of the initial hospital's inability to provide emergency medical care.*

Requirements: Please submit this form along with the following documentation:

- Letter from the initially transported hospital which states that they could not provide emergency medical care appropriate to your needs, and
- Copy of the bill for subsequent private ambulance transport

3) ☐ **City Employment Exemption:** *Pursuant to Los Angeles Administrative Code Section 22.210.2(e), a request for exemption by a City Employee or members of Police Reserve Corps for EMS service provided for an illness or injuries that occur during the course and within the scope of employment.*

Requirements: Please submit this form along with the following documentation to the address listed above:

- Letter from employee's supervisor on Department letterhead that includes the following: Employee Name; EID#; Date and Time of Illness/Injury; Location (address) of Illness/Injury; and statement that the illness or injury occurred during and within the scope of employment. *Sample letter available upon request.*

SUBMISSION INSTRUCTIONS

Submit this application and all required supporting documentation within 30 days of the initial billing date to the address listed at the top of this form.

PATIENT ACKNOWLEDGEMENT AND SIGNATURE (Required)

I certify under penalties of perjury that the information and supporting documentation provided pursuant to this request is correct and complete.

Patient Signature _____ Date _____

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