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Ambulance Transport Fee Financial Hardship Waiver Form

Applicant Name:		Account #
Applicant Address:		
Monthly Household Income:	Number of Dependents Living in Household:	
I have an exemption of property tax. <input type="checkbox"/> Yes <input type="checkbox"/> No		
I am covered by Health Safety Net (Free Care) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Responsible Party (if different from applicant):		
Name:	Relationship:	
Address (if different from applicant):		

I do hereby request that I, as either the applicant, or the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this EMS transport service fee. By signing this form, I certify that I have no insurance that can be billed for this charge and cannot pay due to financial hardship. I declare that all of the information contained in this document is true and accurate. Further I understand that I may be held liable for any false statements pertaining to this waiver request. I hereby agree to notify the billing agency Pro EMS Solutions of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the ambulance transport fee.

Signature:	Date:
Printed Name:	

For questions regarding the hardship waiver process, please call **(617) 492-8484** *or* via e-mail to: **billing@proems.com**

Mail this application and all attachments to:
Pro EMS Solutions, 31 Smith Place, Cambridge, MA 02138 *or* fax to **617.492.0806**

For Office Use Only:

Run #:	Approval Signature:
Date of Service:	Date Received:
Claim (circle one): Approved Denied	Reason: