If you have been transported by Boston MedFlight and your insurance information was not available at the time or you would like to make payment by a credit card please complete the appropriate section below and fax (781-863-2791) or mail to BMF Attention: Billing Office.

Thank You

(PLEASE PRINT)

Primary Insurance: ____________________ Eff. Date: ________

Policy Number: ____

Group Number: ____

Address: ____

____

Subscriber Name: _____________________________________

*If injury is work-related, give injury date: ____________________

Employer Name: ______________________________________

Employer Address: ____________________________________

____

Employer Telephone: ___________________________________

Claim/File Number: ____________________________________

*If injury is motor vehicle related, give injury date: _____________

Insurance Address: ____________________________________

____

MassHealth RID#: _____________________________________

Secondary Insurance: ____________________ Eff. Date: ________

Policy Number: ____

Group Number: ____

Address: ____

____

Subscriber Name: _____________________________________

IF PAYING BY CREDIT CARD, FILL OUT BELOW
☐ MASTERCARD ☐ VISA ☐ AMEX ☐DISCOVER
CARD NUMBER
SIGNATURE
AMOUNT
EXP DATE