EMS Revenue Recovery
Transport Fee Hardship Request

Transport Fee Hardship Request

Applicant Name:

Applicant Address:

Phone Number: Date of Transport:

Responsible Party (If not the same as applicant):

Name:

Address:

Phone Number:

REASON FOR REQUEST:

I hereby request that I, as either the applicant or responsible party for the above named applicant, be considered for a reduction in my payment responsibilities for ambulance transport services. I certify that the above information is true and accurate to the best of my knowledge.

Signature of: Date

☐ Applicant

☐ Responsible Party

If you have any questions, please call (866) 330-8272.

Please mail completed form to:

County of Louisa

PO Box 11

Louisa, VA 23093

ADMINISTRATIVE USE ONLY

Incident #: DAB Invoice #:

Date of Service: Date Received:

Date DAB Notified: Approval Signature:

(Form Revision 9/16/08)