

# Please provide your insurance information.

## Guarantor/Responsible Party Information

**RUN NUMBER:**

Name:		Relationship to Pt.:		
		Phone #		
Address:	Street:	City:	State:	Zip:

## Primary Insurance Information

Primary Ins. Name:		Policy #		
		Group #		
Primary Ins. Address:	Street:	City:	State:	Zip:
Insured's Name:				

## Secondary Insurance Information (If Applicable)

2 <sup>nd</sup> Ins. Name:		Policy #		
		Group #		
2 <sup>nd</sup> Ins. Address:	Street:	City:	State:	Zip:
Insured's Name:				

If this was an auto accident or work related, please circle:    **Auto**    **Work Related**

Auto or Worker's Comp Insurance Name:		Claim #		
Primary Ins. Address:	Street:	City:	State:	Zip:

Submit to: Transport Billing Office  
PO Box 12383  
Mill Creek, WA. 98082

You may also fax the form to **360-282-3947**, or email it to, [billing@firedistrict7.com](mailto:billing@firedistrict7.com)