



AMBULANCE TRANSPORTATION  
REVENUE RECOVERY PROGRAM

**COMPASSIONATE BILLING CERTIFICATION FORM**

THIS FORM MUST BE COMPLETED FOR EACH  
AMBULANCE TRANSPORT BILLING

Applicant Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Applicant Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Responsible Party (If not the same as Applicant):  
Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address (If different than Applicant): \_\_\_\_\_

In accordance with the Compassionate Billing Policy adopted by the Board of Supervisors of Spotsylvania County, I hereby attest and affirm the following responses to be true and accurate to the best of my knowledge:

Please check the appropriate response:

- 1. The applicant is a resident of Spotsylvania County. Y  N
- 2. The responsible party is a resident of the County. Y  N
- 3. The applicant owns real estate in Spotsylvania County. Y  N
- 4. The responsible party owns real estate in Spotsylvania County. Y  N
- 5. The applicant pays personal property taxes in Spotsylvania County: Y  N
- 6. The responsible party pays personal property taxes in Spotsylvania County. Y  N
- 7. The applicant is covered under a health insurance plan either as the insured or a dependent of the insured. Y  N
- 8. The applicant is elderly or disabled and qualifies for real estate tax relief pursuant to County ordinance. Y  N
- 9. The responsible party is elderly or disabled and qualifies for real estate tax relief pursuant to County ordinance. Y  N
- 10. The combined family income of the applicant is less than \$100,000 annually. Y  N
- 11. The combined family income of the responsible party is less than \$100,000 annually. Y  N

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 understand that I will be held liable for any false statements made herein. I agree to notify Spotsylvania County of any change in the status of the applicant or the responsible party that may affect their qualification for reduction in payment responsibility.

Signature of: \_\_\_\_\_ Date \_\_\_\_\_  
 Applicant  
 Responsibility party

*If you have any questions, please call (540) 507-7922.  
Please mail completed form to:  
Spotsylvania Fire and Rescue  
P. O. Box 818  
Spotsylvania, VA 22553*

**ADMINISTRATIVE USE ONLY**

Incident#: \_\_\_\_\_ Invoice #: \_\_\_\_\_  
Date of Service: \_\_\_\_\_ Date Received: \_\_\_\_\_  
Claim Approved/Denied (Reason): \_\_\_\_\_  
Date Notified: \_\_\_\_\_ Approval Signature: \_\_\_\_\_  
(Form Revision 10/28/10) Date: \_\_\_\_\_