SACRAMENTO METROPOLITAN FIRE DISTRICT

Billing Dispute Form

Please complete all applicable fields and provide any supporting documentation with this dispute form.

Patient Information

Patient Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email (If Available): _____

Account Information

Date of Service: _____

Incident Number / Run Number: _____

Amount Due: $_____

Reason for Review

Please explain why you are requesting a review of your account. Include any information you believe should be considered when evaluating your request.

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Certification

I certify that the information provided on this form is true and complete to the best of my knowledge. I understand that my request will be reviewed based on the information submitted and that additional information may be requested if necessary.

Patient Signature: _____ Date: _____

Please email completed form to emsbilling@metrofire.ca.gov or mail to:
Metro Fire
Attn: EMS Division
10545 Armstrong Ave, Suite 200
Mather, CA 95655