



**FAIRFAX COUNTY FIRE AND RESCUE
EMS TRANSPORT BILLING PROGRAM**

Request for Transport Fee Waiver

THIS FORM MUST BE SUBMITTED FOR EACH EMS TRANSPORT INCIDENT BILLED

APPLICANT NAME: _____

ADDRESS: _____

**RESPONSIBLE PARTY
NAME IF NOT THE
APPLICANT:** _____

**MONTHLY HOUSEHOLD
GROSS INCOME:** \$ _____ **HOUSEHOLD SIZE (# of People):** _____

I am applying to Fairfax County Fire and Rescue to request a waiver of payment for my EMS transport fee. I certify that I have no insurance that can be billed for this charge, that the above information is true and accurate to the best of my knowledge, and that I will be held responsible for any false statements made herein.

Signature

Date

If you have any questions please call (703)246-2266. Please mail completed form and applicable documents to:

**FAIRFAX COUNTY VIRGINIA
P.O. BOX 630232
BALTIMORE, MD 21263-0232**

ADMINISTRATIVE USE ONLY

Annual Gross Income based on information provided: \$ _____

DAB Invoice#: _____

____ **Approved**

____ **Claim Denied Due to** _____

Date DAB notified: _____ **Approval Signature/Date** _____