EXCELSIOR SPRINGS AMBULANCE MEMBERSHIP PROGRAM APPLICATION

☑ **YES!!!** I would like to have peace of mind. Please enroll me in the Excelsior Springs Ambulance Membership Plan for Emergency Ambulance Service

To enroll fill in the requested information as it applies to you. Sign the consent form, and send or bring the form along with **$60.00** to:

Excelsior Springs Fire Department
1120 Tracy Ave.
Excelsior Springs, MO 64024

Please make checks payable to ***City of Excelsior Springs.***

Eligible Head of Household	**Eligible Spouse**
Name:	Name:
Address:	Date of Birth:
City: State: Zip:	Social Security Number:
Phone Number:	Medicare Number:
Date of Birth: Social Security Number:	Medicaid Number: N/A
Medicare Number:	BC/BC I.D. Number
Medicaid Number: N/A	BC/BS Group Number:
BC/BS I.D. Number: Group Number:	

Other Insurance	
Insurance Company Name:	Family Coverage?
Carried Through (ie...Employer, union)	Is Spouse Covered?
Policy Number:	
Address Claims to be Submitted to:	
City State Zip	
Phone Number:	

All memberships are for a 12-month period.

Turn to back of page for Membership Terms and Agreement- PLEASE SIGN ON BACK

Membership Terms and Agreement

I hereby apply for Membership in the Excelsior Springs Ambulance Membership Program for myself and other eligible members of my household. The $60.00 per household, per year membership fee provides **Medically Necessary Emergency Ambulance Services**, in the Excelsior Springs Fire Department response area, at no out-of-pocket expense to me. I understand that Non-Emergency (routine) transports, and Non-Medically Necessary transports as defined by the Centers for Medicare and Medicaid Services are not covered under the membership plan and will be billed separately.

Members must be 55 years of age or older, and must be residents within the corporate limits of the City of Excelsior Springs, Missouri or the Eastern Clay County Ambulance District.

I understand that this membership permits the City of Excelsior Springs to collect directly from my insurance and any third party agency (Medicare, Medicaid, Blue Cross Blue Shield, etc.) whatever benefits or payments may be available. I understand that by paying the $60.00 per year membership fee, that there will be no additional out-of-pocket expense to me or any other eligible member of my household. I also understand that the membership fee is non-refundable, and non-transferable.

Please Note: Some individuals with Medicare may not benefit from this program due to the fire department having contractual obligations with Medicare. If you have a Medicare supplemental insurance policy you may not receive any benefit from this program; you will need to contact your supplemental insurance provider to determine if you will benefit from this program.

Individuals receiving Medicaid benefits are not eligible for this program secondary to federal laws.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND WAIVER:

I hereby authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services or its intermediaries, carriers and any private insurance company information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of this original and request payment of medical insurance benefits to the party who accepts assignments.

_____ _____

Signature, Eligible Head of Household **Date**

_____ _____

Signature, Eligible Spouse **Date**

ASSIGNMENT OF INSURANCE PAYMENT AGREEMENT

I hereby authorize payment of all insurance benefits, including Major Medical, Title XVII Medicare, Title XIX Medicaid, or any other private insurance to the holder of this authorization.

_____ _____

Signature, Eligible Head of Household **Date**

_____ _____

Signature, Eligible Spouse **Date**