American Medical Response Ambu-Care Membership Agreement

January 3, 2018 - January 2, 2019

By signing the 2018-2019 AMR Membership Application, I agree on behalf of myself and the family members of my household listed on the Application, to abide by the terms of AMR's 2018-2019 Membership Program, as set forth in this Agreement. I understand that my membership will expire on midnight January 2, 2019. I understand that Medicaid patients are not permitted to enroll in this program.

PERSONS COVERED: This Agreement covers the household family members listed in my Application, so long as they remain full-time members of specified household and the children listed are 26 years of age or younger and a full time student. New household members may be added, family members may be deleted or the household location may be changed by written notice to AMR, effective the day following receipt by AMR of such notice.

COST OF MEMBERSHIP: To become an AMR member, I hereby pay AMR a non-refundable and non-transferable fee of $60.00/YR with Primary and Secondary insurance, $67.50/YR with primary insurance only, or $400.00/YR with no insurance. I warrant that all information in the Application is true and correct. AMR reserves the right to request documentation demonstrating the accuracy of such information. **Enrollment is allowed year-round, and the fee is pro-rated for the number of months enrolled during the program period.** **PAYMENT FOR SERVICES:** I acknowledge that I am legally responsible for the ambulance services provided to me, but that my membership will assist me by discharging that part of my financial liability that is not covered by insurance for those AMR services specified in this Agreement. This benefit is subject to certain limitations specified in this Agreement. I request and assign payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf or on behalf of other household family members covered by the Agreement to AMR directly for any ambulance services and supplies furnished to me by AMR whether in the past, now, or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as AMR, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services whether in the past, now or in the future. I agree to cooperate with AMR or its agent in collecting any such benefits. I acknowledge that I have been provided with a copy of AMR's Notice of Privacy Practices. I expressly authorize AMR or its agents or associates to contact me or any responsible party at any phone number provided, including any cellular phone number provided, for the purpose of resolving any unpaid balances or other pertinent issues. Patient or Guarantor agrees that such contact may be made to any mailing address, telephone number, cellular phone number, e-mail address, or any other electronic address that Patient or Guarantor has provided, or may in the future provide, to AMR. Patient or Guarantor agrees and acknowledges that any e- mail address or any other electronic address that Patient or Guarantor provides to AMR is Patient's or Guarantor's private address and cannot be accessed by unauthorized third parties. Patient or Guarantor agrees that in addition to individual persons attempting to communicate directly with Patient or Guarantor, any type of contact described above may be made using, among other methods, pre-recorded or artificial voice messages delivered by an automatic telephone dialing system, pre-set e-mail messages delivered by an automatic e-mailing system, or any other pre-set electronic messages delivered by any other automatic electronic messaging system. Patient or Guarantor also authorizes AMR or its agents or associates to obtain a credit report to assist in the collection of any unpaid balances. Nothing herein shall relieve me from the direct financial responsibility for any charges not paid by an insurer. I further agree to send promptly to AMR any payments that an insurer forwards to me.

BENEFITS: Payment of membership fee and compliance with the terms of this Agreement entitles members to the following benefits:
a. Emergency ambulance services: Members who receive medically necessary advanced or basic life support emergency ambulance services from AMR as a result of an 'emergency medical condition,' shall pay nothing out of pocket, except as specified herein.

b. Non-emergency ambulance services: Members who receive medically necessary advanced or basic life support non-emergency ambulance services from AMR shall pay nothing out of pocket, except as specified herein.
"Medical necessity" for purposes of determining whether any emergency or non-emergency transport qualifies for the membership benefit shall be determined by AMR using the standards of the Medicare program, which are also used by many other insurance programs. AMR reserves the right to require a certificate of medical necessity from a qualified physician in determining medical necessity. Without limiting the foregoing, transports to doctors' or dentists' offices; or outpatient trips to or transfers to another medical facility for the patient's family or physician's convenience, are generally not considered medically necessary.

LIMITATIONS AND CONDITIONS: Membership benefits only extend to AMR's advanced or basic life support ambulance services staffed with paramedics and EMT/Is, and EMTs. Membership benefits are inapplicable to services rendered by any other provider.
As a condition of receiving the benefits of membership with respect to any ambulance transport, a member with insurance must comply with all coverage conditions of the applicable insurance program for such transport. Some insurance programs require the insured person to obtain prior authorization of payment for non-emergency, yet medically necessary ambulance services. Some plans require certain documentation from the insured with a specified time limit, or the plans deny or reduce coverage for ambulance services. In the event a member with insurance forfeits coverage by failing to comply with these types of requirements for a transport that would otherwise be covered by membership, or the services are denied as covered, then AMR shall provide the member with a 50% discount of its usual and customary charge for such transport. Non-insured household family members will receive a 50% discount for services rendered.
Membership only covers ambulance services that begin in Ellis County and terminate in the service area(s): Ellis County, Arlington, Fort Worth, & Dallas hospitals. No benefits are provided for services rendered outside of these areas. I agree to pay AMR for any services it provides that are not covered by the membership benefit at 100% usual customary rates for non-medically necessary transports.

AMR reserves sole discretion to deny or revoke membership and to refund membership fees (in full or in part) for reasonable cause, including but not limited to failure to comply with the terms of this Agreement. If AMR revokes my membership, I will pay all balances in full.

AMR reserves the right to discontinue its membership program at any time upon notice to members. In such event, AMR shall return a pro-rated portion of the membership fee. AMR also reserves the right to unilaterally modify the terms of membership. AMR may assign its right or duties under this agreement.

- If you have no insurance, or your insurance denies your medically necessary claim, AMR will bill you for 50% of the usual and customary charges.
- All family members, up to the age of 26 years or younger, living at your residence are covered under one membership, provided they are listed below.
- We will complete all necessary paperwork, file claim and negotiate with your insurance company.
- Memberships are effective from the month you sign up through January 2, 2019

Do not send cash. Make check or money order payable to AMR (American Medical Response).

PLEASE ATTACH COPIES OF BOTH THE FRONT AND BACK OF ALL YOUR PRIMARY AND SECONDARY INSURANCE CARDS.

Ambu-Care APPLICATION

January 3, 2018 - January 2, 2019

Please complete all information below and sign the *Ambu-Care* membership agreement. Return your completed form with your payment to AMR, Ambu-Care, **2250 W. HWY 287 Business Waxahachie, TX 75167**, (469) 383-3766

Is this a ☐ Renewal or ☐ New Application?

First Name________________ Middle Initial_______ Last Name________________

Home Address________________ City________________ Zip Code________________

Home Phone #________________ Email Address________________@________________

SS #_______-_______-_________ Date of Birth________________ Male ☐ Female ☐

Primary Insurance________________ Policy #________________ Phone #________________ Group #________________

Insurance Company Address________________

Supplemental Insurance________________ Policy #________________ Group #________________

Supplemental Insurance Address________________ Phone #________________

Insured Employer Name________________ Address________________

Other Family Members of Household

First Name________________ Middle Initial_______ Last Name________________

SS #________________ Date of Birth________________ Male ☐ Female ☐

Primary Insurance________________ Policy #________________ Phone #________________ Group #________________

First Name________________ Middle Initial_______ Last Name________________

SS #________________ Date of Birth________________ Male ☐ Female ☐

Primary Insurance________________ Policy #________________ Phone #________________ Group #________________

First Name________________ Middle Initial_______ Last Name________________

SS #________________ Date of Birth________________ Male ☐ Female ☐

Primary Insurance________________ Policy #________________ Phone #________________ Group #________________

Do not send cash – make check or money order payable to AMR (American Medical Response)

PLEASE ATTACH COPIES OF BOTH THE FRONT AND BACK OF ALL YOUR PRIMARY AND SECONDARY INSURANCE CARDS.

All membership applicants 19 years of age or older must sign below with signature of other adult member.

I hereby apply for membership in the Ellis County Ambu-Care Membership program. I have reviewed the Ambu-Care Membership Agreement and agree to abide by the terms thereof. I request payment of authorized Medicare or other insurance benefits to me, or on my behalf, to be paid to AMR (American Medical Response), in order to determine benefits payable on my behalf, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of the other members of my household, if they are minors or otherwise unable to sign.

X____ Date ________________

X____ Date ________________

X____ Date ________________

Signature of other adult member

**Within 30 days of receipt of the completed application and fee, members will receive correspondence from AMR confirming that their application and fee have been processed.