A Global Medical Response Solution

For Office Use Only:
Acct#_____
Div. **LOB**

AMR LIFECARE MEMBERSHIP APPLICATION

MAIL THIS FORM AND PAYMENT TO THE ADDRESS BELOW

Membership covers all listed residents of your household for one year from effective date

Complete the **Head of Household** for self membership and any additional blocks for **Other Members of Household** wishing to participate

Head of Household

First:_____ MI:____ Last:_____ SS#:_____ Date of Birth:_____

Address:_____ City:_____ County:_____ ST:_____ Zip:_____

Phone Number: _____

Primary Insurance:_____ Policy#:_____ Group#:_____

Company Address:_____ City:_____ ST:_____ Zip:_____ Phone:_____

Secondary Insurance:_____ Policy#:_____ Group#:_____

Company Address:_____ City:_____ ST:_____ Zip:_____ Phone:_____

Other Members of Household

First:_____ MI:____ Last:_____ SS#:_____ Date of Birth:_____

Primary Insurance:_____ Policy#:_____ Group#:_____

Company Address:_____ City:_____ ST:_____ Zip:_____ Phone:_____

Secondary Insurance:_____ Policy#:_____ Group#:_____

Company Address:_____ City:_____ ST:_____ Zip:_____ Phone:_____

Other Members of Household

First:_____ MI:____ Last:_____ SS#:_____ Date of Birth:_____

Primary Insurance:_____ Policy#:_____ Group#:_____

Company Address:_____ City:_____ ST:_____ Zip:_____ Phone:_____

Secondary Insurance:_____ Policy#:_____ Group#:_____

Company Address:_____ City:_____ ST:_____ Zip:_____ Phone:_____

All membership applicants 19 years or older must sign below

I hereby apply for membership in the AMR Membership program. I have reviewed the AMR Membership Agreement on back 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 AMR for any ambulance services and supplies furnished to me by AMR. I authorize any holder of medical information about me to release that information to the Centers for Medicare and Medicaid Services, its agents and carriers, or AMR, 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 other members of my household, if they are minors or otherwise unable to sign.

Primary Member Signature:_____ **Date:**_____

Other Participant Signature:_____ **Date:**_____

Other Participant Signature:_____ **Date:**_____

The fee for Membership or renewal is $65.00 per household.

Method of Payment ☐ Check

Mail to: Lifecare Membership Program, PO Box 847199, Dallas TX 75284-7199

AMR MEMBERSHIP AGREEMENT 2021
PLEASE KEEP THIS FOR YOUR RECORDS

By signing the 2021 AMR Membership Application ("Application"), I agree, on behalf of myself and the members of my household listed on the Application, to abide by the terms of AMR's 2021 Membership Program, as set forth in this Agreement. My membership will begin the day after AMR receives my Application and payment, and will expire one year from this day. Since Medicaid patients do not have any co-payment or deductible for Medicaid covered ambulance transportation, Medicaid patients do not need to enroll in this program. Ambulance services are required to accept the Medicare allowed amount for Medicare covered services ("Medicare allowable"). If the service is covered by Medicare (i.e., if the ambulance service provided is a covered benefit and the service provided meets all coverage conditions such as, but not limited to, medical necessity), the membership will discharge the member's financial responsibility for any co-payments or deductibles. Patients who have other insurance that covers these co-payments and deductible amounts, such as "Medigap" policies, may not need to enroll in this program.

PERSONS COVERED: This Agreement covers the household members listed in my Application, so long as they remain full-time members of the specified household. New household members may be added, 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. References to "I" or "me" and similar references shall be construed as including all such household members.

COST OF MEMBERSHIP: To become an AMR member, I hereby pay AMR a non-refundable and non-transferable fee in the amount specified in the Application. I warrant that all the information in the Application is true and correct. AMR reserves the right to request documentation demonstrating the accuracy of such information. In the event of any change in the insurance coverage or status specified on the application, I agree to notify AMR within ten (10) days and, if the change results in the affected member(s) owing an additional membership fee, I agree to pay the additional amount upon receipt of an invoice from AMR specifying the additional amount due. Failure to notify AMR of any such change or to pay any additional amount due within thirty days of the invoice date shall result in the automatic termination of this Agreement without any notice to the affected member.

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by AMR, but that my membership will assist me by discharging that part of my financial liability that is not covered by the ambulance service benefits of my insurance for those AMR services specified in this Agreement. This benefit is subject to certain limitations specified in this Agreement. As a condition of receiving this benefit, I hereby assign (hand over) to AMR all rights and benefits that I or the other members of my household have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for ambulance services. Such payment sources are collectively referred to in this Agreement as "insurance." I authorize payment of all insurance benefits or payments to AMR.

I understand that AMR will, whenever it deems it feasible, file claims for and directly collect the benefits payable from insurance, up to the amount of AMR's charges for its services. When requested by AMR, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receive any insurance or other third party payments for ambulance services provided by AMR, I will promptly turn over those payments to AMR.

BENEFITS: Payment of the membership fee and compliance with the terms of this Agreement entitle members to the following benefits:

a. Emergency ambulance services: Members, who receive medically necessary advanced or basic life support emergency ambulance services from AMR 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's 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/or EMTs. *No benefits are provided for specialized forms of medical transportation such as mobile intensive care transports or specialty care transports, staffed with one or more registered nurses or other personnel functioning above the normal paramedic level* . Membership benefits are inapplicable to services rendered by any other provider. Further, membership does not apply to wheelchair van service.

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 ambulance services. Some plans require certain documentation from the insured within a specified time limit, or the plans deny or reduce coverage for ambulance services. In the event ambulance services rendered by AMR to the member are not covered by the member's insurance due to lack of medical necessity, failure to comply with applicable coverage requirements or for any other reason, or if the member has no applicable insurance, AMR shall provide the member with a 20% discount off of its usual and customary charge for such transport.

Membership only covers ambulance services that begin and terminate in the following service area(s): Linn County, Kansas. No benefits are provided for services rendered outside this area.

I agree to pay AMR for any services it provides that are not covered by the membership benefit.

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 rata portion of the membership fee. AMR also reserves the right to unilaterally modify the terms of membership. AMR may assign its rights or duties under this Agreement.

SIGNATURE REQUIRED ON APPLICATION

American Medical Response
LifeCare Program
PO Box 847199
Dallas TX 75284-7199
Phone 800.913.9106