APPLICATION FOR MEMBERSHIP
AMERICAN MEDICAL RESPONSE
Harrison and Hancock Counties, MS

A Global Medical Response Solution

FOR OFFICE USE ONLY

DIV._____ LOB _____ ACCT. # _____

MAIL FORM & PAYMENT TO: AMR Membership, 12020 Intraplex Parkway, Gulfport, MS 39503

FEES: If head of household has both primary and secondary insurance, pay **$60.00**. If head of household has one form of insurance or no insurance, pay **$63.00**. Your fee covers fulltime residents of your household through **July 31, 2021**.

Permanent Address of Applicants_____City_____State_____Zip_____

County of Residence _____ Phone (_____) _____

HEAD 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 MEMBER 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 MEMBER 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_____

Please attach other pages to include more members of your household.

PAYMENT METHOD: ___Visa ___MasterCard (Account #_____Expiration Date_____)
___Cash ___Check ___Money Order *We cannot process credit card payments without account number and expiration date.*

I have read the membership agreement, Form AP20-21. I agree to its terms and I certify that the persons listed above are current residents of my household. I hereby state that, when I receive services from American Medical Response (AMR), I am responsible for payment of the same, except where otherwise provided by law or by the terms of my membership with AMR. I request that payment of authorized Medicare or other insurance benefits be made whether 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 to the Centers for Medicare and Medicaid Services (CMS) or any other third party payor or its agents and carriers, as well as AMR, any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, now or in the future. I have been notified by AMR that prior authorization may be required for non-emergency transport. If prior authorization is required but not obtained, I will assume all responsibility for all charges not paid by my insurance carrier(s) except as provided by the terms of my membership with AMR. Copies of this authorization may be used in place of the original.

X_____ **PRINTED NAME**_____ **DATE**_____

Signature **from primary member authorized to sign for entire household. Then print name and enter date.**

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Membership Agreement

Please Retain a Copy of this Document for Your Records

By signing the 2020—2021 AMR Membership 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 2020-2021 Membership Program, as set forth in this Agreement. My membership will begin the day after AMR receives my Application and payment, and will expire at midnight on July 31, 2021. 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. (See question 3 on Question & Answer page.)

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 after AMR receives such notice. A nursing home bed or assisted living facility apartment is a household unto itself. References to "I" or "me" and similar references are interpreted to include all household members.

COST OF MEMBERSHIP: To become an AMR member, I hereby pay AMR a non-refundable and non-transferable fee 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 a change in the insurance coverage or status specified on the Application, I will notify AMR within ten (10) days and, if the change results in affected member(s) owing an additional membership fee, I agree to pay the additional amount on 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 (30) days of the invoice date shall result in the automatic termination of this Agreement without 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 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 collects 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 membership fees 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 service from AMR shall pay nothing out of pocket, except as specified herein (see "c").
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 (see "c" below).
c. Uninsured AMR ambulance services: When insurance does not pay AMR for its services, AMR provides the member a 40% discount off its usual and customary charges for services ordered and provided with a good faith belief that the services are medically necessary.

MEDICAL NECESSITY: To determine whether any emergency or non-emergency transport qualifies for membership benefits, AMR will use the "medical necessity" 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 & 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 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 and are inapplicable to AMR's wheelchair van service.

As a condition of receiving 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 40% discount off of its usual and customary charge for such transport.

SERVICE AREA; Membership covers qualified ambulance services from AMR that begin and terminate within or among Mississippi and Louisiana. No benefits apply to 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 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 (transfer) its rights or duties under this Agreement.

*****PLEASE SIGN THE FRONT OF THE APPLICATION FORM*****