



TRI-COUNTY AMBULANCE ASSOCIATION

APPLICATION FOR MEMBERSHIP

(Please Print)

Last Name _____ First _____ M.I. _____

Mailing Address _____ Apt. # _____

City _____ State _____ Zip _____

Social security number _____ Date of birth (D.O.B.) _____ Sex _____

Telephone number _____ Street Address (if different than above) _____

City _____ State _____ Zip _____

List spouse and children under 21 regularly living at home (First name, middle initial, last name if different.)

Spouse _____	D.O.B. _____	Sex _____	SS# _____
Name _____	D.O.B. _____	Sex _____	SS# _____
Name _____	D.O.B. _____	Sex _____	SS# _____
Name _____	D.O.B. _____	Sex _____	SS# _____
Name _____	D.O.B. _____	Sex _____	SS# _____
Name _____	D.O.B. _____	Sex _____	SS# _____

(Attach a list if additional space is needed)

Do you have any insurance that pays medical benefits? yes no

Member's Medicare # _____ Spouse Medicare # _____

Name of Primary Health Insurance _____ Policy ID# _____ GRP.# _____
Address _____

Other health insurance _____ Policy ID# _____ GRP.# _____
Address _____

Other health insurance _____ Policy ID# _____ GRP.# _____
Address _____

Name of auto insurance _____ Policy# _____
Address _____

YOUR ANNUAL PAYMENT IN THE AMOUNT OF \$45.00 MUST ACCOMPANY THIS APPLICATION.
Return to: Tri-County Ambulance Association, P.O. Box 9, Heppner, OR 97836.

I HAVE ENCLOSED PAYMENT BY:

<input type="checkbox"/> Cash	Membership fee	\$45.00
<input type="checkbox"/> Money order	Tax deductible donation	_____
<input type="checkbox"/> Check	Total enclosed	_____

X _____
MEMBER'S SIGNATURE (I have read & agree to the statement on the reverse side.)

TRI-COUNTY AMBULANCE ASSOCIATION

COVERAGE BEGINS ON THE FIRST DAY OF THE MONTH FOLLOWING RECEIPT OF THE APPLICATION MATERIALS. COVERAGE EXTENDS FOR THE PERIOD OF ONE YEAR.

I understand that Tri-County Ambulance Association membership does not provide insurance coverage. Membership allows participating ambulance services (utilized by myself or a family member) to bill my insurance for any applicable medical benefits. I authorize the release of medical information for the purpose of ambulance insurance billing only. I agree that my membership covers myself and my immediate family. For the purposes of this agreement, immediate family is defined as any spouse and all unmarried children under the age of twenty-one living in my household. Other family and/or non-family living in my household are considered a separate family and must obtain a separate membership.

I understand that Tri-County Ambulance Association will accept payment from my insurance companies as payment in full for covered services. Should I or a family member receive payment for ambulance service rendered, I will immediately forward the payment to the appropriate ambulance service organization. I also understand that I will be responsible for my own deductible (as defined by my insurance policies) and that I will be billed for any amounts applied against the deductible.

I understand that the \$45 annual fee provides emergency pre-hospital medical care and ambulance transportation within the Tri-County region. These benefits are also provided with reciprocating ambulance organizations throughout Oregon. I understand that medically necessary ambulance services are covered by my membership and that I will not be billed for them. Some non-emergency services may also be covered—even when insurance coverage is denied. With Tri-County membership, I will not be billed for non-emergency transport as long as emergency personnel determines that this service is warranted. Emergency transfers between medical facilities will also be covered if authorized by a physician and medically necessary.

Non-emergency services NOT covered by this agreement are transports which can be pre-arranged. The following non-emergency transports are NOT covered by this agreement:

- > Transfers to or from doctors' offices or clinics for routine appointments;
- > Transfers to or from a nursing home to a doctor's office, clinic or hospital for treatment or routine care which is normally provided at the nursing home;
- > Non-medically necessary transfers when other means of transportation could be used. Other means of transportation would be private vehicle, wheelchair van, taxi or other non-emergency vehicles. Example: transfer back home from the hospital after being checked and/or treated at the hospital if the patient's condition does not warrant an Emergency Medical Technician's care.

If I feel I must use an ambulance for non-emergency services and I insist upon transport against emergency personnel's determination of medical necessity, I understand that I will be billed by the ambulance organization for this service.

TO THE INSURANCE CARRIERS

I authorize payment of insurance benefits for ambulance service for myself and family members directly to the billing authority in accordance with the ambulance agreement and as itemized on submitted claims.

RECIPROCAL BILLING AGREEMENT

I authorize release of all information required for billing purposes to any ambulance provider that has an authorized reciprocal billing agreement with the Tri-County Ambulance Association. I further authorize any such ambulance provider from whom we have received service to directly bill their charges to my health insurance carriers.