# Osage County EMS Ambulance Service Membership Agreement and Consent Form

**(Please keep this form for your records)**

I am hereby applying for an Osage County Ambulance Service Membership for myself and/or my household family members which shall include spouse/domestic partner, children or any other family member CURRENTLY LIVING in my residence. I have listed each household member's name on the form where appropriate.

Membership covers MEDICALLY NECESSARY emergency and non-emergency ambulance transports to the closest appropriate treating hospital originating in Osage County, Nemaha County or Jackson County. Osage County Membership is not an insurance policy. Membership does not cover patients who are able to transport themselves or have other means of transportation safely (examples: by car, taxi, family member, friends or wheelchair van). Medicaid recipients are not eligible due to Medicaid requirements. Membership covers MEDICALLY NECESSARY transports that fall under Medicare guidelines for medically necessary transports. (Other restrictions do apply)

A Physician Certification Statement (PCS) documenting the MEDICAL CONDITION that deems ambulance transport a MEDICAL necessity shall be required for any transport denied by your insurance. Non- emergent transports must be pre-authorized with your insurance provider if required.

**The membership fee is non-refundable, and membership is non-transferable.**

OCEMS shall directly collect any insurance benefits that include Primary, Secondary, Auto or Commercial Insurance that may be available. Members shall be responsible to pay any remaining balances not covered by any of the above insurance policies.

Emergency transports MAY be covered when medically necessary. An "emergency" is an unforeseen medical condition which requires urgent and unscheduled medical attention. After all available insurance policies have paid, any remaining balance is then reduced by 40%. If no insurance coverage is available or benefits are denied by your insurance company, OCEMS members are charged a reduced fee (60% of billable charges).

**This Membership is valid for transports used by Osage County EMS, Nemaha County EMS and Jackson County EMS.**

I hereby assign OCEMS all rights and benefits of mine and of my dependents for ambulance services provided by insurance. I further authorize all commercial insurances to pay directly to OCEMS any benefits that may be available for services rendered to myself or my dependents by OCEMS, and agree to provide all necessary insurance information. If I receive a payment directly from any insurance agency, I will immediately forward the payment to OCEMS. I understand that with this membership ***payment of any remaining balance is expected within 30 days unless otherwise arranged with Osage County EMS***. If I fail to comply or follow through with payment arrangements, I understand my membership can be terminated and full charges for all services will be immediately due.

*Our Profession...Our Passion...EMS*

For more information, questions or concerns please contact Osage County EMS billing office at (785) 364-1911
Or visit our Website at KSEMS.com

## Renewal for Osage County Ambulance Service Membership

I would like to renew my Osage County Ambulance Service Membership for another year/2 years. I am sending the completed form with payment (check/ money order/credit card information) made payable to Osage County EMS.

| With insurance (please check box) | Without Insurance (please check box) |
|---|---|
| ☐One Year Membership $55 | ☐One Year Membership $99 |
| ☐Two Year Membership $99 | ☐ Two Year Membership $189 |

### Membership Form

Head of Household:_____ Date of Birth:_____

Address:_____ City:_____ State:_____

Zip:_____ Phone #:_____ SSN:_____

Primary Insurance: _____ ID: _____

Secondary Insurance: _____ ID: _____

### Family Plans

Please list every household member to be covered other than the Primary member above:
(Relationship: Enter 1-Spouse 2-Child 3-Other)

**(2)**Spouse/Partner:_____ DOB:_____ SSN:_____ _Relationship:____

**(3)**Dependent:_____ DOB:_____ SSN:_____ Relationship:____

**(4)**Dependent:_____ DOB:_____ SSN:_____ Relationship:____

**(5)**Other Member: _____ DOB:_____ SSN:_____ Relationship:____

(Should you have more dependents, please add on back of this form.)

### Insurance Information

**(2) *Primary Insurance*:**_____ Policy ID#:_____

Secondary Ins.:_____ Policy ID#: _____

**(3) *Primary Insurance*:**_____ Policy ID#:_____

Secondary Ins.:_____ Policy ID#: _____

**(4) *Primary Insurance*:**_____ Policy ID#:_____

Secondary Ins.:_____ Policy ID#: _____

**(5) *Primary Insurance*:**_____ Policy ID#:_____

Secondary Ins.:_____ Policy ID#: _____

### Credit Card Payment Method/Signature

Check Method of payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

_____ _____ _____

Name on Credit Card (please print) Credit Card Number Expiration Date

Signature of Credit Cardholder _____

**PLEASE MAIL BOTH FORMS TO: Osage County EMS, PO Box 109, Holton, KS 66436**

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# Osage County EMS Ambulance Service Membership Agreement and Consent Form

(Please return this with completed Membership Form)

I hereby authorize any holder of medical, hospital, or other records and information about me or my dependents to release to OCEMS, third party agencies, the Center for Medicare or Medicaid Services (CMS) and its intermediates any information needed to determine third party benefits payable for any services provided to me or my dependents by OCEMS now or in the future. (Dependents under 18 do not have to sign as parent/legal guardian signature is acceptable)

Head of Household Signature: _____ Date: _____

(2)Spouse/Partner Signature: _____ Date: _____

(3)Dependent Signature: _____ Date: _____
(If over 18 years of age)

(4) Dependent Signature: _____ Date: _____
(If over 18 years of age)

(5) Other Family Member Signature: _____ Date: _____
(If over 18) Relationship: _____

Because the Membership Program is important to us at OCEMS, we hope our members will take the opportunity to refer a friend or family member. Simply give us their information and we will do the rest.

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

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