CITY OF READING EMERGENCY MEDICAL SERVICES

Thank you for your interest in joining the City of Reading Emergency Medical Services Ambulance Membership Plan. The annual ambulance membership fee is $45.00 for a person or $70.00 per household.

To join the Reading EMS Ambulance Membership Plan, please follow the instructions below:

1. **Complete the required information on the reverse side of this form.**

2. **Head of household must sign the contract portion below.**

3. **Enclose your check or money order for $45.00 for a single member or $70.00 per household payable to: City of Reading EMS. <u>Please do not send cash.</u>**

4. **Return the entire form in the enclosed addressed envelope.**

5. **A receipt will be issued upon receipt of payment.**

CITY OF READING EMS MEMBERSHIP CONTRACT

I understand that I or my family must use the services of the City of Reading EMS to be eligible for the benefits provided by membership. I understand that the membership fee provides me or my family, emergency medical care. Any transportation within the City of Reading EMS service area will be at no additional out of pocket expense to me provided it is *medically necessary*. I authorize the City of Reading EMS to bill my insurance carrier or third party payor for any customary charges associated with the service. The City of Reading EMS agrees to accept such payment, if any, as payment in full for those eligible benefits.

I further understand that this is not an insurance policy. I also understand that emergency calls have first priority and the need for transportation is determined by City of Reading EMS staff.

I understand that this membership plan is non-refundable or transferable.

- **Medically necessary as defined by federal guidelines.**

**** For Medicaid recipients, this membership is for non-covered services (i.e., services beyond Medicaid program benefits.) Medicaid services will be billed to Medicaid.**

Head of Household
Signature:____ Date:____________

(over)

CITY OF READING EMERGENCY MEDICAL SERVICES

NAME ____
(FULL NAME INCLUDING MIDDLE INITIAL)

ADDRESS ____

CITY________________ STATE___ ZIP CODE_________ PHONE# (   ) -_____-_________

DATE OF BIRTH _________________ SOCIAL SECURITY # ________________________

INSURANCE INFORMATION:
PRIMARY HEALTH INSURANCE ____
(EXAMPLE: MEDICARE)

POLICY OR GROUP NUMBER ____

SECONDARY HEALTH INSURANCE: ____
(EXAMPLE: 65 SPECIAL)

POLICY OR GROUP NUMBER ____

NAME ____
(FULL NAME INCLUDING MIDDLE INITIAL)

ADDRESS ____

CITY________________ STATE___ ZIP CODE_________ PHONE# (   ) -_____-_________

DATE OF BIRTH _________________ SOCIAL SECURITY # ________________________

INSURANCE INFORMATION:
PRIMARY HEALTH INSURANCE ____
(EXAMPLE: MEDICARE)

POLICY OR GROUP NUMBER ____

SECONDARY HEALTH INSURANCE: ____
(EXAMPLE: 65 SPECIAL)

POLICY OR GROUP NUMBER ____

(PLEASE LIST ANY ADDITIONAL MEMBERS ON A SEPARATE SHEET)