Butte County EMS Ground Ambulance Application for Membership

$100 FAMILY
One Year Membership

***Please Check One:** ❑ Family ❑ New Member ❑ Renewal or Current Member

Please Print (Head of Household)

Last Name _____ Telephone ( ) _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Email Address _____

Mailing Address (if different from above) _____

City _____ State _____ Zip _____

Household members:
List only dependents who are claimed on your tax return.
Please list any last name that is different than the Head of Household name above.

	Last Name (If different from Head of Household)	First Name	Middle Initial	Relationship to Head of Household	Date of Birth
Head of Household					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					
Dependent					

Please complete both sides and return this sheet with your payment.

Butte County EMS Ground Ambulance Membership Agreement

(Please read this statement carefully, then sign below)

I hereby apply for membership in the Butte County EMS Ground Ambulance Membership program for myself and eligible members who live at my address. I understand the enclosed fee provides emergency ambulance care and transportation within the Butte County EMS Ground Ambulance Service area, inter-facility transfers and non-emergency ambulance service as noted below. Coverage begins 3 days after acceptance of the application and extends one full calendar year from that date. Non-emergency ambulance service to hospitals and inter-facility transport from our local hospital to other approved facilities is covered when medically necessary. I understand that Butte County EMS Ground Ambulance Membership program is not insurance, but will provide ambulance service through the Butte County EMS Ambulance Service and will bill whatever insurance or medical benefits I may have. I further authorize the release of medical information for the purpose of ambulance insurance billing only. Should a family member or I receive payment from insurance or other medical benefits provider for ambulance service rendered by the Butte County EMS Ground Ambulance Service, I will immediately forward such payment to the Butte County EMS Ground Ambulance Service. Butte County EMS Ground Ambulance Membership program is not solicited from persons who receive Medi-Cal medical benefits and such membership constitutes a voluntary contribution only. I understand that violations of the terms of this agreement may result in immediate cancellation. This membership is non-refundable and non-transferable.

TO THE INSURANCE CARRIER

I authorize a copy of this agreement to be used in lieu of the original on file at the Butte County EMS Ground Ambulance office. The original may be furnished on request. I authorize payment of insurance benefits for ambulance service, for myself or family members, directly to Butte County EMS Ground Ambulance Service, according to the Butte County EMS Ground Ambulance Membership agreement and as itemized on the attached claims. I have paid the co-payment for ambulance service to be rendered and expect your usual and customary ambulance reimbursement on my behalf to be sent directly to the Butte County EMS Ground Ambulance Service.

I understand that Butte County EMS Ground Ambulance will be used only for medically appropriate transports and that Butte County EMS Ground Ambulance will bill a member's insurance plan, if any, but will not bill the member-patient for any remaining balance.

Applicant Signature **Date**

Please mail completed application to:

Butte County EMS Ground Ambulance Membership
1531 Esplanade
Chico, CA 95926

A check, money order or credit card information must accompany this application. Please make check payable to Butte County EMS.

I have enclosed my payment by:

❑ Check ❑ Money Order ❑ Cash ❑ Mastercard ❑ VISA ❑ DISCOVER

Credit Card # / / / Expiration Date / CCV Code

Your cancelled check, credit card statement or money order receipt is proof of membership.
Please complete both sides and return with your payment.