Pinnacle EMS Member Plan

Yell County Medical Transport, LLC d/b/a Pinnacle EMS ("PEMS")
PLAN APPLICATION – New Member

Name _____ **Birth Date** _____
Address _____ **SSN** _____
_____ **Phone** _____
City, State Zip _____ **Male or Female** (circle one)

Insurance Name **Insurance Address** **Policy or ID Number**

_____

_____

SUBSCRIPTION FEES (Annual)

The category selected below must be true for all family members to be covered by this agreement. If family members have different levels of insurance coverage, the subscription fee will be based on the family member with the least amount of insurance coverage.

__ **$50.00 Member with Primary (Medicare) and Supplemental**

__ **$60.00 Member with Primary Insurance (or Medicare) only**

__ **$70.00 Member with no Insurance**

PAYMENT METHOD

__ **Personal Check** (Please return with this application form. Make payable to: PEMS)

__ **Money Order** (Please return with this application form. Make payable to: PEMS)

__ **Visa or Mastercard** _____ **Expiration Date** _____ **CVV #** _____

PLEASE DO NOT SEND CASH

AUTHORIZATION AGREEMENTS

A membership to this PEMS Plan will cover co-payments and deductibles on all medically necessary emergency ambulance transportation. This membership also will cover co-payments and deductibles required by nonemergency ambulance transportation if that transportation is approved by member's insurance. For all other medically necessary services provided by PEMS, a 40% discount from billed charges will be provided. Membership does not apply if transported by an ambulance company other PEMS.

I understand that this PEMS Plan is not an insurance policy and that PEMS will bill and receive payments from my insurer, Medicare, or other third party. I authorize payment of insurance or other benefits for ambulance transportation directly to PEMS, 1701 Shackleford, Little Rock, AR 72211. I authorize any holder of medical information about me to release to PEMS and its agents, CMS or government agency, and/or any other third-party payors, any information or documentation needed to determine these benefits or the benefits payable for related services, now or in the future. I agree that a copy of this authorization is as effective as the original and request that payment available from any source be made payable directly to PEMS. If payment(s) are made or sent to me, I agree to immediately endorse and forward them to PEMS. I understand I am financially responsible to PEMS for charges not covered by this Authorization and guarantee payment of all charges within 45 days from the date of service. I further agree that if collection is made necessary by lawsuit or otherwise, I agree to pay all collection costs including a reasonable attorney's fee.

Signature: _____ **Date:** _____

Medicaid recipients will have limited benefits; Ambulance transportation is fully covered by Medicaid. All subscriptions are non-refundable.

ADDITIONAL FAMILY MEMBER INFORMATION

Please provide the following health insurance and family member information.
All members must live with the subscriber at the same street address as the subscriber.

FAMILY MEMBER 1

Name_____ SSN_____ Birth Date_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name Insurance Address Policy or ID Number

_____

_____

Signature:_____ **Date:** _____

By signing this document, I certify that I have read the Authorization Agreements.

FAMILY MEMBER 2

Name_____ SSN_____ Birth Date_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name Insurance Address Policy or ID Number

_____

_____

Signature:_____ **Date:** _____

By signing this document, I certify that I have read the Authorization Agreements.

FAMILY MEMBER 3

Name_____ SSN_____ Birth Date_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name Insurance Address Policy or ID Number

_____

_____

Signature:_____ **Date:** _____

By signing this document, I certify that I have read the Authorization Agreements.

FAMILY MEMBER 4

Name_____ SSN_____ Birth Date_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name Insurance Address Policy or ID Number

_____

_____

Signature:_____ **Date:** _____

By signing this document, I certify that I have read the Authorization Agreements.