TURNER FIRE DISTRICT

7605 3rd Street SE
TURNER, OR 97392
(503) 743-2190

$60

APPLICATION FORM

PLEASE COMPLETE ALL SECTIONS OF THIS FORM—BOTH PAGES

Last Name:_____ **First Name:**_____ **MI:**___

Date of Birth:___-___-____ **Phone:(__)**_____

Mailing Address:_____

Street address:_____

City:___ **State:**__ **Zip Code:**_____

Email:_____

DEPENDENTS INFORMATION:

List spouse, children under 21, and other dependents listed on your tax return and living at home. Please include full first name, middle initial and last name for each person listed below.

Spouse/Domestic Partner:_____ **DOB:**___-___-___

Name:_____ **DOB:**___-___-___

Name:_____ **DOB:**___-___-___

Name:_____ **DOB:**___-___-___

Name:_____ **DOB:**___-___-___

As a FireMed member, your FireMed enrollment fee does more than protect you from unexpected ambulance bills. Your membership fee covers all ambulance expenses and protects you from any out-of-pocket expenses. This partnership provides financial peace of mind for you and your loved ones and allows us to serve you better.

By signing this application, you accept the terms and conditions of the Turner FireMed Membership Agreement. Annual membership runs March 1 through the end of February the following year.

Applicant Signature: **Date:**

PAYMENT INFORMATION

Return completed and signed application form with $60.00 payment to:
Turner Fire District—FireMed, 7605 3rd Street SE, Turner, OR 97392
All credit card transactions will be assessed a 2% processing fee.

OFFICE USE ONLY

PAYMENT RECEIVED DATE ____/_____/_____ **RECEIPT NUMBER (CASH ONLY)**_____

CHECK NUMBER_____ **INVOICE**_____ **ROSTER/BILLING AGENCY**_____

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Insurance Information

Primary Insurance

Insurance Company : _____

Policy # : _____ **Group # :** _____

Name of Insured Person: _____

Agent: _____ **Insurance Phone #** _____

Secondary Insurance

Insurance Company : _____

Policy # : _____ **Group # :** _____

Name of Insured Person: _____

Agent: _____ **Insurance Phone #** _____

Tertiary Insurance

Insurance Company : _____

Policy # : _____ **Group # :** _____

Name of Insured Person: _____

Agent: _____ **Insurance Phone #** _____

Please note: Some insurance companies will cover the household, but will give each member their own policy number. Please attach additional pages if needed so we can complete our records.

Thank you!

FIREMED AGREEMENT

Coverage starts from acceptance of the application and extends through February of the following year.

I understand that Turner FireMed membership coverage is not insurance. The membership fee represents the pre-payment of any uninsured portion of a member's ambulance bill whether I have insurance or not. Turner Fire District Ambulance is a provider that will bill my insurance for medical benefits which I may have. I authorize the release of medical information for the purpose of ambulance insurance billing only. If I am a member and do not have insurance, Turner FireMed accepts my membership fee as payment in full for all of my ambulance bill.

Turner FireMed 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 by Turner Fire District Ambulance Service, I will immediately forward the payment to Turner FireMed at 7605 3rd St. SE, Turner, Oregon 97392. My membership fee covers any applicable deductible, co-insurance, or co-payment amounts and I expect the usual and customary ambulance reimbursement on my behalf to be sent directly to Turner Fire District Ambulance.

I understand that the $60.00 annual fee provides pre-hospital emergency medical care and ambulance transportation within the Turner Fire District Ambulance service area.

Membership covers patient out-of-pocket expenses for medically necessary emergency ambulance transport to an emergency room. Non-emergency medically necessary ambulance service with pre-authorization by a physician are covered when transporting to an emergency room.

THE FOLLOWING NON-EMERGENCY TRANSPORTS ARE <u>NOT</u> COVERED BY TURNER FIREMED MEMBERSHIP:

Non-emergency transfers out of Turner Fire District Ambulance service area, either origin or destination.

Transfer to or from doctors' offices or clinics for examination, x-ray, diagnostic procedures or treatments.

Transfers to or from a nursing home to a doctor's office, clinic, or hospital for treatment or care which is normally provided at a nursing home.

Non-medically necessary transfers when other means of transportation could be used. Other means of transportation would be private vehicle, wheelchair vans, taxi, or other non-emergency vehicles.

TO THE INSURANCE CARRIER

I authorize payment of insurance benefits for ambulance service for myself and my covered family members directly to the Turner Fire District Ambulance Service according to the Turner FireMed agreement and as itemized on submitted claims on our behalf.

RECIPROCAL BILLING AGREEMENT

I authorize Turner FireMed to release all information required for billing purposes to any ambulance provider that has an authorized reciprocal billing agreement with Turner FireMed. I further authorize any such ambulance provider from whom myself and or my family have received service to directly bill their charges to my health insurance carriers.

TURNER FIRE DISTRICT FIREMED

7605 3rd St. SE
Turner, OR 97392

Phone: 503-743-2190
Fax: 503-743-3604