



**LifeCare  
Subscription Plan  
Application**

**915 Hinman St.  
Prescott, AZ 86305  
(800) 418-5523  
(928) 445-3814**

**New**  **Renewal**

Head of Household			Spouse				
Last Name		First Name	MI	Last Name		First Name	MI
Social Security No.		DOB: / /		Social Security No.		DOB: -	
Age:	Sex: __ M __ F	Marital status: __ S __ M __ D __ W		Age:	Sex: __ M __ F	Marital status: __ S __ M __ D __ W	
Home address:				Home address:			
City, state, ZIP:				City, State, ZIP:			
Home telephone:				Home telephone:			
Nearest relative's name (not living with you): Relationship: Telephone:				Nearest relative's name (not living with you): Relationship: Telephone:			
Primary Insurance Co.: Address:				Primary Insurance Co.: Address:			
City, state, ZIP:				City, state, ZIP:			
Group name:		ID No.: _____ Group No.: _____ Group ID: _____		Group name:		ID No.: _____ Group No.: _____ Group ID: _____	
Secondary Insurance Co.: Address:				Secondary Insurance Co.: Address:			
City, state, ZIP:				City, state, ZIP:			
Group name:		ID No.: _____ Group No.: _____ Group ID: _____		Group name:		ID No.: _____ Group No.: _____ Group ID: _____	
Dependents (under 21 and living at home)							
Name:		DOB:	Sex:	Name:		DOB:	Sex:
1.				4.			
2.				5.			
3.				6.			

**LifeCare Membership Contract**

I understand that payment of the annual membership fee entitles myself and listed **Household Members (defined as spouse and/or unmarried dependent children under age 21 living at the same address)** to emergency and non-emergency ground ambulance transportation, that is medically necessary as defined by the Center for Medicare Services, from within Life Line Ambulance's approved service area (as defined by accompanying information sheet) to the nearest appropriate medical facility, for a period of one year, or until September 30. I understand that my membership may be automatically renewed by paying the full membership fee then in existence before September 30. I understand that this is a billing agreement only. The agreement does not provide for free ambulance service. Only Members on this agreement are covered.

I understand that twenty-four (24) hour advance scheduling and physician authorization is required for all non-emergency services. I understand that emergency calls have priority over non-emergency calls. I understand that Life Line Ambulance is not responsible for reimbursement of payments of services provided by any other ambulance service, unless Life Line Ambulance specifically requests other ambulance services.

I understand that, although the patient is responsible for payment for services rendered, because of membership, Life Line Ambulance will only require any and all available insurance or third-party payer reimbursement as payment in full, and Life Line Ambulance will not seek any other reimbursement from Member. However, Life Line Ambulance reserves the right to charge members at the rate currently approved by the Arizona Department of Health Services, at the time transport is made, for one-way, patient-loaded mileage for the transports which originate within Life Line Ambulance's service area, but which terminate outside said service area. I agree to cooperate with claim submission to, and to assign Life Line Ambulance, all payments and benefits from any insurance company or other third-party payer.

I agree to immediately send Life Line Ambulance any reimbursement payments from insurance or third-party payer paid directly to me for services rendered by Life Line Ambulance. Failure to do so will result in revocation of membership. For Members who are Medicare recipients, the membership fee shall be applied to any applicable deductibles and co-insurance.

I understand that membership is non-transferable. **Membership becomes effective, and membership fee is nonrefundable, after three (3) business days from the date the agreement is received by, and membership fees paid in full to, Life Line Ambulance.** Life Line Ambulance may cancel this agreement with or without cause by giving thirty (30) days' written notice to Members, together with a prorated refund of the membership fee. I understand that Members are required to immediately advise Life Line Ambulance of any changes in address, insurance carrier, plan, policy, third-party payer information and additions or deletions of household members. I understand that failure to promptly provide such notice of change may result in the Member being held fully responsible for all applicable charges for ambulance transports and other services rendered by Life Line Ambulance.

I understand that Members authorize any holder of medical information about Members to release to Life Line Ambulance any information necessary to determine or assign benefits payable from insurance or third-party payers for services rendered by Life Line Ambulance. I understand members assign and authorize payment to be made directly to Life Line Ambulance or its representatives. I hereby specifically authorize Life Line Ambulance to release/receive any information to the Social Security Administration CMS, its carriers or any party necessary for payment of this obligation, now and in the future.

*I agree to the provisions outlined in this agreement. I certify all information is correct as of this date. I acknowledge I have received a copy of Life Line Ambulance's privacy practices.*

Member's signature: \_\_\_\_\_  
Spouse's signature: \_\_\_\_\_

Date: \_\_\_\_\_  
Date: \_\_\_\_\_

Please attach your check for \$49.71, and make it out to Life Line Ambulance.

Life Line Ambulance also accepts Visa and MasterCard.

Revised 7/30/07

<b>Office Use Only</b>
Effective Date: _____