

# Ambulance Service Can Cost \$600 Or More Per Trip

**With MemberCare From  
LifeCare Ambulance  
It's Just \$38 A Year**

## How MemberCare works:

- LifeCare will bill Medicare or your insurance company for any medically necessary ambulance trips to the closest, appropriate medical facility. Any co-pays or deductibles your insurer requires you to pay are covered by MemberCare.
- Your membership becomes effective 3 days after receipt of payment and a signed membership agreement.
- If the insurance company sends you the check, you must forward the check to LifeCare Ambulance but you are not responsible for any balance remaining.
- Medically necessary ambulance trips that are not covered by insurance, are rendered at a 20% discount from regular rates.
- You will receive a membership card.

**FOR MORE INFORMATION, CALL 269-565-4148  
or 1-800-267-1161**

**Visit our website [www.lifecareems.org](http://www.lifecareems.org)**

## **MemberCare Membership Contract**

## **Terms and Conditions**

I understand that the \$38 annual fee for MemberCare covers out-of-pocket expense for services covered by my insurance, including coinsurance and deductibles, of LifeCare Ambulance Service bills for medically necessary ambulance transportation to or from area hospitals. I understand that the membership is effective three (3) days after receipt of full payment and a signed membership agreement.

I understand that MemberCare is not an insurance or health-maintenance organization (HMO) and that LifeCare will bill and receive claim payments from my insurer or third-party agency (an HMO, Medicare, Blue Cross, etc). To facilitate processing of authorized claims, I request that payment of authorized insurance benefits be made on my behalf to LifeCare Ambulance or myself, for any ambulance service and supplies furnished by LifeCare Ambulance. I authorize holder of medical information concerning me, to release to the Centers for Medicare and Medicaid Services and its carriers or other insurance companies, as well as to LifeCare Ambulance, any information needed to process all claims now and in the future and to determine these benefits or the benefits payable for related services. I consent to the use and disclosure by LifeCare Ambulance Service of my protected health information (PHI) for purposes of treatment, payment and health care operations, for reporting to local medical control authorities, and for the purposes of business associates in support of all of the foregoing. This authorization remains in effect until I revoke it in writing.

I permit a copy of this authorization to be used in place of the original. If the insurance company sends a check to me for services rendered by LifeCare Ambulance Service, I agree to promptly forward that check to LifeCare Ambulance Service. LifeCare Ambulance Service reserves the right to require a physician certification of medical necessity for all non-emergency transports by ambulance. I understand that medically necessary ambulance trips that are not covered by insurance, are rendered at a 20% discount from regular rates per trip, and that I am responsible for payment.

**I understand that my MemberCare membership fee covers not only me, but my immediate family members (spouse and any children) living with me who I declare as dependents on this year's federal income tax form.**

I understand that my membership covers ground services provided by LifeCare Ambulance Service, within its service area including western Calhoun County, all of Branch County, southern Barry County, Bellevue Township and Village, northeastern Kalamazoo County, St. Joseph County and Cass County to or from area hospitals.

The membership agreement must be signed by the insurance policyholder or authorized person. I understand LifeCare Ambulance Service reserves the right to reject or revoke membership benefits if it has evidence of abuse of this program. I understand that this membership is non-transferable and non-refundable. **I affirm that I have read and agreed to the terms as described above.**

**THIS CONTRACT EXPIRES ONE YEAR FROM ENROLLMENT**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_