Lower Columbia FireMed Enrollment Application

Membership runs November 1st-October 31st

Primary Member Information

Name (Last/First/MI):_____ Date of Birth:_____

Mailing Address:_____ City, State, and Zip:_____

Phone #:_____ Email:_____ Gender:_____

Additional Household Members *(please list additional members on a separate sheet of paper)*

Name (Last/First/MI):_____ Date of Birth:_____

Name (Last/First/MI):_____ Date of Birth:_____

Name (Last/First/MI):_____ Date of Birth:_____

Name (Last/First/MI):_____ Date of Birth:_____

The FireMed Membership fee is $50 and covers your entire household*

* Household definition on reverse of this application. Please read the FireMed Agreement on the back side of this page. By signing this application, you agree to the terms of membership.

X_____
Primary Member

X_____
Spouse

Administrative Use Only

Date Rcvd: _____

Payment Method: _____

Receipt #:_____

Gift Membership (Y/N): _____

New Member (Y/N):_____

PLEASE MAKE CHECKS PAYABLE TO FIREMED OR ENTER CREDIT CARD INFO BELOW

CRFR & Clatskanie members, please mail application to 270 Columbia Blvd, St Helens OR 97051.

Mist/Birkenfeld members, please mail application to 12525 Hwy 202 Mist OR 97016

Card #:_____ Exp. _____ 3 Digit Security Code _____

PLEASE READ THIS AGREEMENT IN ITS ENTIRETY BEFORE SIGNING THE MEMBERSHIP AGREEMENT ON THE REVERSE SIDE

The Lower Columbia FireMed Membership Program is a voluntary service available to residents living within the Clatskanie, Mist/Birkenfeld, Rainier, and St Helens Service Areas. I hereby apply for a FireMed Membership for myself and my dependent family/household members* who live at my address for the FireMed Fiscal Year (running November 1st-October 31st). I understand that membership fees provide only medically necessary** pre-hospital care and transportation within the FireMed reciprocal areas. Should I, or any of my dependent family/household members, be transported by ambulance under the FireMed Agreement, I request that payment of authorized Medicare, Medicaid, or any other Insurance Benefits be made on my behalf to the ambulance supplier for any services provided to us past, present, or future. I understand that this authorization may be used by the supplier for all services until such time that I revoke this authorization in writing. I agree to immediately remit to my ambulance supplier any payment that I receive directly from insurance or any other source whatsoever for the services provided to me or my family and I assign all such payments to my ambulance supplier. I authorize appeals of payments or denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to my ambulance supplier and its billing agents and/or the Centers for Medicare and Medicaid Services and its carriers and agents and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by my ambulance supplier, now or in the future. I understand that I may get a copy of my ambulance suppliers Notice of Privacy Practices at the local office. A copy of this form is as valid as the original.

- I understand that medical transportation is based on medical necessity, NOT on membership status and that patients will be transported to the closest medically appropriate facility.
- I understand that my membership covers only ambulance transports in our reciprocal area which are medically necessary.
- I understand that FireMed does not cover transports between hospitals, and will not cover transports by non-participating agencies.
- I understand that FireMed is NOT insurance, but will provide service through the FireMed reciprocal agencies. FireMed will bill whatever insurance or medical benefits I may have and is entitled to primary and secondary insurance payment.
- I transfer, directly to the provider of service, my rights to insurance payment from my primary and secondary insurance carrier as payment in full. Such payment shall not exceed regular charges. Should a family member or I receive payment from insurance or other medical benefits provider for ambulance services rendered by a FireMed Reciprocal Agency, I will immediately forward such payment to the provider of service.
- I further authorize the release of medical information for the purpose of ambulance insurance billing only.
- FireMed membership is not intended to solicit Medicaid enrolled patients. **PLEASE DO NOT ENROLL IN FIREMED IF YOU ARE CURRENTLY A MEDICAID ENROLLED PATIENT.**
- I understand that violations of the term of this agreement may result in immediate cancellation. This membership is non-refundable, non-transferrable, and not pro-rated.
- New member benefits take effect after receipt of completed application and payment, plus 24 hours.

***Definition of Family:** FireMed Membership covers immediate family members living in the same household. The members, spouse, unmarried children under age 26, and other persons listed as legal dependents for income tax purposes are covered. Others not included in this definition are required to obtain their own separate membership.

****Definition of Medically Necessary**: Medical Necessity is satisfied when "lack of transport" could place the patient's health in serious jeopardy; could cause impairment of bodily functions; or another mode of transportation could endanger the health of the patient.

Member benefits in other areas Member benefits are extended to areas outside of the local FireMed service area within the State of Oregon. FireMed benefits outside of Oregon are covered with agencies belonging to the National Association of Reciprocating EMS. These benefits are limited to the terms of agreement in effect by each individual FireMed participating agency at the time the benefits are used. Members who receive ambulance service from any other FireMed participating agency are eligible for benefits offered by that agency.