

2011-2012 AMBU-CARE MEMBERSHIP CONTRACT

I understand that I must use the services of American Medical Response (AMR) in order to be eligible for benefits provided by this membership. I understand that the membership fee provides me and my qualified family members emergency and nonemergency ambulance service. I request payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf to AMR for any ambulance services and supplies furnished to me by AMR, whether in the past, now or in the future. I authorize any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contractors, as well as AMR, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related services, whether in the past, now or in the future.

AMR agrees to accept such payment as payment in full for those eligible benefits. I further understand that all services which are determined to be not medically necessary, not covered by my insurance, or other than to or from a hospital are rendered at a membership discount rate of 20%. (Wheelchair service is available in parts of Kent and Ottawa Counties at a discount of 20% off the standard rate.)

I also understand that emergency calls have first priority, and the need for medical transportation will be determined by the medical staff of AMR, and that routine medical transfers require physician authorization. This membership covers ground transportation only.

I understand that this membership is nonrefundable and nontransferable. (This membership takes effect two days after AMR's business office receives my completed and signed membership application and my annual membership fee.)

I affirm that I have read and agree to the terms of this membership as described in the above "Ambu-Care Membership Contract."
This membership contract remains in effect through April 2012.

X _____ Signature	X _____ Spouse's Signature
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NAMES OF COVERED MEMBERS

(self, spouse, unmarried children under age 21 living at home)

	First Name	Last Name	Date of Birth	Sex (M or F)	Social Security #

Home Address:				Phone:	
City:	State:			Zip:	
Mailing Address:				Phone:	
City:	State:			Zip:	

	Health Ins Co Name	INS. ID#	Medicare No
Self			
Spouse			
Child			
Child			

Mail To	
<input type="checkbox"/> My Check or Money Order for \$40 made payable to AMR is enclosed.	AMR 517 S Division Grand Rapids MI 49503
<input type="checkbox"/> Please charge my credit card for the \$40 annual fee.	CARD # Exp CVC Code (security code)