



TURNER FIRE DISTRICT

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

\$50

APPLICATION FORM

PLEASE COMPLETE ALL SECTIONS OF THIS FORM

Last Name: _____ First Name: _____ MI: _____
 Date of Birth: ____ - ____ - ____ Social Security Number: _____ - _____ - _____
 Mailing Address: _____ Phone: (____) _____
 Street address: _____
 City: _____ State: _____ Zip Code: _____

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.

Spouse: _____ DOB: ____ - ____ - ____ SSN#: _____
 Name: _____ DOB: ____ - ____ - ____ SSN#: _____
 Name: _____ DOB: ____ - ____ - ____ SSN#: _____
 Name: _____ DOB: ____ - ____ - ____ SSN#: _____
 Name: _____ DOB: ____ - ____ - ____ SSN#: _____

INSURANCE INFORMATION

Do you have insurance that pays medical benefits? _____ Yes _____ No.
 Your MEDICARE #: _____ Spouse MEDICARE #: _____
Your Primary Ins. Name: _____ **Your** Primary ID #: _____
Your 2nd Ins. Name: _____ **Your** 2nd ID #: _____
 Spouse Primary Ins. Name: _____ Spouse ID No.: _____
Your Primary Group #: _____ **Your** 2nd Group #: _____ Spouse Primary Group #: _____

I authorize payment of insurance benefits for ambulance service for myself and family members listed above directly to Turner Fire District Ambulance according to the Turner FireMed agreement and as itemized on submitted claims. 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 we have received service to directly bill their charges to my health insurance carriers.

Member's Signature _____ *Date* _____

PAYMENT INFORMATION

_____ Payment by check or money order enclosed _____ Payment by credit card (**information below**)
 Credit Card Number: _____ Expiration date: _____
Circle one: VISA MC

Applicant's Signature _____ Date _____

**Return completed and signed application form with \$50.00 payment to:
Turner Fire District—FireMed, 7605 3rd Street SE, Turner, OR 97392**

FIREMED AGREEMENT

Coverage starts from acceptance of the application and extends to February 28th 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 P.O. Box 10, 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 \$50.00 annual fee provides pre-hospital emergency medical care and ambulance transportation within the Turner Fire District Ambulance service district.

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 NOT COVERED BY TURNER FIREMED MEMBERSHIP:

Non-emergency transfers out of Turner Fire District Ambulance area of service, 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 STREET SE
TURNER, OR 97392

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