



EMERGENCY MEDICAL SERVICES

AMBULANCE SUBSCRIPTION APPLICATION

IT IS IMPORTANT TO NOTE THAT MEDICAID RECIPIENTS ARE NOT ELIGIBLE FOR THIS PROGRAM, BY LAW

I hereby apply for membership in the Corsicana Fire Rescue Ambulance Subscription Program. I understand that the enclosed annual fee will provide coverage for me, my spouse, and children less than 25 years of age who live at my residence.

I understand that through this subscription, the Corsicana Fire Rescue E.M.S. will provide emergency ambulance service within their service area and to hospitals. I also understand and give authorization to the Corsicana Fire Rescue E.M.S. to bill my insurance and to obtain benefits that are entitled through my insurance carriers. This subscription will cover the portion not reimbursed by my medical coverage for services provided by the Corsicana Fire Rescue E.M.S. during the coverage period of my subscription membership.

I authorize the release of all medical information for the purpose of billing my insurance. I understand that should I or any member of my family covered under this subscription program receive payment from insurance or any other medical provider for services rendered by the Corsicana Fire Rescue E.M.S., the payment will immediately be forwarded to City of Corsicana, P. O. Box 732664 Dallas, TX 75373-2664 in the amount necessary to satisfy any outstanding balance.

I understand that Corsicana Fire Rescue E.M.S. provides **medically necessary** ambulance transportation and that any violations of the terms of this agreement may result in immediate cancellation of my membership or other penalty. I also understand that this membership is non-refundable and non-transferable.

HEAD OF HOUSEHOLD Male _____ Female _____

Last Name _____ First Name _____ Middle Initial _____
Date of Birth _____ Social Security # _____ Medicare # _____ Phone # _____
Mailing Address & Apt. # _____
City _____ State _____ Zip Code _____ County _____
Are you a nursing home resident? Yes _____ No _____ Nursing Home _____

SPOUSE Male _____ Female _____

Last Name _____ First Name _____
Middle Initial _____
Date of Birth _____ Social Security # _____ Medicare # _____ Phone # _____
Mailing Address & Apt. # _____
City _____ State _____ Zip Code _____ County _____
Is spouse a nursing home resident? Yes _____ No _____ Nursing Home _____

OTHER HOUSEHOLD MEMBERS ' INFORMATION (Use a separate sheet if additional space is needed.)

() M () F Last Name _____ First Name & Middle Initial _____
Social Security Number _____ Date of Birth _____
() M () F Last Name _____ First Name & Middle Initial _____
Social Security Number _____ Date of Birth _____

HEALTH INSURANCE INFORMATION (Other than Medicare) This section must be completed for approval.

Insurance Company _____ Policy or ID Number _____
Carried Through (Employer, Union, etc.) _____ Group Number _____
Insurance Company Address _____
City, State, Zip code _____ Insurance Company Phone # _____
Is Spouse Covered? Yes _____ No _____ Is Family Covered? Yes _____ No _____

PAYMENT OPTIONS (Must be signed to be valid.)

() Personal check or money order. Make payable to Corsicana Fire Rescue - 200 N. 12th Street, Corsicana, TX 75110 in the amount of \$48.00. After October 31, 2016 the subscription fee will be prorated at \$4.00 per month. Example to join in Nov. it would be \$44.00.

() I authorize a \$4.00 monthly payment on my water bill (where applicable). Account No. _____

() On-line fee payment at: www.cityofcorsicana.com - **An application form must accompany payment.**

Applicant Signature _____ Date _____