1. *This agreement is between Medic One Ambulance Service, Inc. Hereinafter known as "Ambulance Service" and the Head of Household indicated on the front of this form, herinafter known as "Member". This and the membership enrollment agreement in no way indicates a partnership between Medic One Ambulance Service, Inc. and the head of household or any member of the head of household's family as defined by the Arkansas Partnership Act.*

2. *The terms of the agreement will begin at 8:00 A.M. on the following day after the purchase of this agreement, and will end one year from date of purchase.*

   Membership Fee: ***Single $25.00***
   Household $40.00

   Household definition: Relative living in the same household (same address) up to a maximum of (Six). For households with more than 6 members, a $10.00 charge per member above (Six) will be assessed.

3. *If a Member is currently a member of a competing transportation services membership program and can present proof of such membership, Member shall be entitled to a reduced fee of half price for the first term of their membership with Ambulance Service. Each term thereafter will be charged at the regular fee schedule.*

4. *Ambulance Service agrees to provide **"MEDICALLY NECESSARY"** pre-hospital treatment and transportation to the nearest appropriate facility for medical evaluation and treatment. All emergency situations fall under the term medically necessary. However, non-emergency "Medically Necessary" transports do occur. Ex: Hospital to Hospital or Hospital to Nursing Home. For non-emergency transports to be a covered service, the patient must meet the definition of bed confined using the criteria set by the Health Care Finance and Administration, which says the patient cannot sit, stand, or ambulate. Also, it would be covered if transport by other means endangered the patient's health or life.*

5. *Member agrees that Ambulance Service may bill any and all medical or health insurance policies, plans, or benefit programs, or any other third party the Member may have including, but not limited, Worker's Compensation and Automotive Insurance. Member agrees to assign insurance benefits to Ambulance Service. Member also authorizes release of medical records and other documents, that may be necessary to obtain insurance proceeds until such release is canceled in writing. Member further agrees to forward any payments they receive for services provided by Ambulance Service.*

6. *Uninsured Care Partners will receive a discount down to the present Medicare allowable rates on the date of service for all aspects of the service he or she received instead of the regular full rates. Any services for non-medically, necessary or non-covered services are also billed at the medicare allowable rates.*

7. *Wheelchair van transport is not covered in Care Partner membership.*

8. *This agreement is meant for medically necessary services and services recognized as "Covered Services" under Medicare guidelines. Charges for Ambulance Services for non-covered services or utilization of an ambulance without medical necessity becomes the responsibility of the Member at awarded for any Member or Non-Member.*

9. ***THIS IS NOT AN INSURANCE POLICY, IT IS SIMPLY A MEMBERSHIP PROGRAM.***

PROVIDED BY **MEDIC ONE AMBULANCE SERVICE**

CARE PARTNER MEMBER **EFFECTIVE DATE** ____________________

HEAD OF HOUSEHOLD: ____

DATE OF BIRTH: ________________________ **SSN:** ________________________

MAILING ADDRESS: ____

STREET ADDRESS: ____

CITY: ______________________ **STATE:** __________ **ZIP:** ____________

PHONE: (________) ____________________________________

HOUSEHOLD MEMBERS

						INSURANCE
NAME:	____________	RELATIONSHIP:	____________	AGE:	______	☐
NAME:	____________	RELATIONSHIP:	____________	AGE:	______	☐
NAME:	____________	RELATIONSHIP:	____________	AGE:	______	☐
NAME:	____________	RELATIONSHIP:	____________	AGE:	______	☐
NAME:	____________	RELATIONSHIP:	____________	AGE:	______	☐

Please be advised the Medicaid recipients are not eligible to become Care Members. All cost for covered, medically necessary ambulance service should be paid by Medicaid. If at any time during your membership you become eligible for Medicaid, your Care Partner Membership will be void.

SIGNATURE

By signing below, I acknowledge that I have read and understood the terms and conditions listed on the reverse side of this form. I hereby request that Medic One Ambulance Service, Inc. be dispatched when I request an ambulance.

____________________	____________________	____________
HEAD OF HOUSEHOLD SIGNATURE	PRINT NAME	DATE