

Emergency Medical Service of LeFlore County Ambulance Membership

Last Name of Applicant	Last Name of Spouse	
First Name of Applicant	First Name of Spouse	
Date of Birth	Date of Birth	
Social Security #	Social Security #	
Medicare #	Medicare #	
Medicaid #	Medicaid #	
Applicant Physical 9-1-1 Address	Home Telephone Number	Cellular Phone Number
Insurance Company Name	Insurance Company Name	
Address to Submit Claims	Address to Submit Claims	
ID Number	ID Number	
Group Number	Group Number	
<input type="checkbox"/> IS FAMILY COVERED <input type="checkbox"/> IS SPOUSE COVERED	<input type="checkbox"/> IS FAMILY COVERED <input type="checkbox"/> IS SPOUSE COVERED	
Full name and date of birth is required on each qualified child (see membership agreement) under the age of 21, living in the same household. If additional space is required, attach a separate sheet. S= Son D = Daughter		
	DOB	Relationship S D
		S D
		S D

AGREEMENT: I acknowledge that I am (or my insurance provider) is responsible for payment of ambulance services provided to eligible dependants, and me by EMS of LeFlore County (EMSLC). I understand that it is my responsibility to provide EMSLC with my insurance and third party payor information and that failure to do so, nullifies this agreement. In consideration and payment of the membership fee, I hereby assign to EMSLC all ambulance benefits that I or other covered family member may otherwise be entitled to receive for services received under this program. EMSLC will accept assignment as payment in full for emergency ground transports and for medically necessary non-emergency transports if insurance or other third-party payor coverage provides benefits for the transport. I understand that EMSLC will file my ambulance insurance claims for each covered person and is entitled to receive payment from all insurance benefits or other third-party payors up to the amount of its usual charges. If no insurance or other third-party payor benefits are available or if the insurance company or other third-party payor denies services, I understand that I remain responsible for payment of 60% of the applicable EMSLC fee. Any insurance or third party payments I may directly receive relative to an ambulance transport shall be immediately delivered to EMSLC central business office in Poteau, Oklahoma. This subscription is not transferable and not refundable and may be cancelled for system abuse or other violation of this agreement at the sole discretion of EMSLC.

Applicant Signature	Date Signed
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This agreement supercedes and replaces any previous edition prior to January 2006.

EMS of LeFlore County
Post Office Box 1025 – Poteau, OK 74953
918.647.9270