AMBULANCE SERVICE MEMBERSHIP APPLICATION

CITY OF FOUNTAINS HEART OF THE NATION
KANSAS CITY MISSOURI

I would like to sign up for the KCFD Ambulance Service Membership plan for my household as listed below. I am enclosing the form along with my check or money order made payable to KCFD. (*To pay by credit card, simply fill out the credit card information at the bottom of this form.*)

With insurance ***(please check box)***
- ☐ **One Year for $**59.00
- ☐ **Two Years for $**109.00

Without Insurance ***(please check box)***
- ☐ **One Year for** $99.00
- ☐ **Two Year for** $189.00

KCFD
6750 Eastwood Trafficway
Kansas City, MO 64129
816.924.1700

HEAD OF HOUSEHOLD (please provide information below)		**SPOUSE OR DOMESTIC PARTNER**
Name:		Last Name:
		First Name: Middle Initial:
Address:		Date of Birth:
City/State/Zip:		Social Security Number:
		Medicaid Number:
Day Phone:	Evening Phone:	Medicare Number:
Date of Birth:	Social Security Number:	**IMPORTANT NOTE: IF MEDICAID IS YOUR PRIMARY INSURANCE, YOU ARE NOT ELIGIBLE**
Medicaid Number:	Medicare Number:	

INSURANCE INFORMATION FOR HEAD OF HOUSEHOLD/SPOUSE OR DOMESTIC PARTNER

Insurance Company	**ID Number**	**Group Number**	**City/State**	Please check: ☐ **In Head of Household Name** ☐ **In Spouse/Partners Name** ☐ **In Household Member Name**
Insurance Company	**ID Number**	**Group Number**	**City/State**	Please check: ☐ **In Head of Household Name** ☐ **In Spouse/Partners Name** ☐ **In Household Member Name**
Insurance Company	**ID Number**	**Group Number**	**City/State**	Please check: ☐ **In Head of Household Name** ☐ **In Spouse/ Partners Name** ☐ **In Household Member Name**

HOUSEHOLD MEMBERS *(See membership agreement below for definition of household.)*

Last Name	**First Name**	**Middle Initial**	**Relation**	**Social Security Number**	**Date of Birth**
Last Name	**First Name**	**Middle Initial**	**Relation**	**Social Security Number**	**Date of Birth**
Last Name	**First Name**	**Middle Initial**	**Relation**	**Social Security Number**	**Date of Birth**
Last Name	**First Name**	**Middle Initial**	**Relation**	**Social Security Number**	**Date of Birth**

CREDIT CARD PAYMENT METHOD/SIGNATURE *(Please do not send cash.)*

Check method of payment: ☐ **MasterCard** ☐ **Visa** ☐ **Discover** ☐ **American Express**

_____ _____ _____

Name on Credit Card *(please print)* **Credit Card Number** **Expiration Number**

Signature of Credit Cardholder: _____

IMPORTANT: ALL PARTICIPANT SIGNATURES MUST ACCOMPANY APPLICATION. MAIL BACK TO KCFD.

One Team. One Job. One Mission.

KCFD Ambulance service Membership Agreement and Consent Form

I hereby apply for a KCFD Ambulance Service Membership for myself and my (household) which includes spouse/domestic partner, parents, children, grandchildren, or siblings of mine or my spouse/domestic partner living in my residence or in a nursing home and have listed each household member's name on the form where appropriate.

Membership covers MEDICALLY NECESSARY **emergency and non-emergency KCFD ambulance trips to or from hospitals originating in Kansas City, MO, Avondale, Oakview, South Platte County, Riverside and Northmoor.** KCFD membership is not an insurance policy**. Membership does not cover: (1) trips for patients who can walk, (2) sit in a wheelchair or (3) be transported by private car or taxi.** Medicaid recipients are not eligible, due to certain Medicaid requirements**.** Membership only covers MEDICALLY NECESSARY transports**. [Medicare guidelines determine medical necessity.] (*Others restrictions do apply*.)**

A Physician Certification Statement (PCS) documenting the MEDICAL CONDITION **that makes ambulance transportation a MEDICAL necessity is required for all non-emergency trips and may be required on emergency trips that are denied by Medicare or other third party agencies. Pre-authorization must be secured prior to non-emergency transports for those patients whose insurance requires such authorization.**

The membership fee is non-refundable, and membership is non-transferable.

Membership permits KCFD to collect directly from any third party agency (private insurance, Medicare, etc.) benefits that may be available. Members and their household members are legally responsible to pay for KCFD services. KCFD will accept any available third party benefits as payment in full.

Emergency transports are fully covered when medically necessary. ***An "emergency" is an unforeseen medical condition which requires urgent and unscheduled medical attention. Transports are fully covered if insurance or other third party coverage provides payment toward benefits for the transport. If no insurance or other third party coverage is available or benefits are denied by the insurance company or third party payer, KCFD members are charged a reduced fee (70% of billable charges).***

PLEASE SIGN AND RETURN COMPLETED FORM TO KCFD
Please note all adult household members must sign.

I hereby assign KCFD all rights and benefits of mine and of my dependents for ambulance services provided by all third party agencies. I further authorize all third party agencies to pay directly to KCFD benefits that may be available for services rendered to me or my dependents by KCFD and I agree to help KCFD collect these benefits. If I receive a payment directly from any third party agency, I will immediately forward the payment to KCFD. If I fail to comply, I understand my membership can be terminated and regular charges for all services will be immediately due.

I hereby authorize any holder of medical, hospital or other records and information about me or my dependents to release to KCFD, third party agencies, the Center for Medicare and Medicaid Services (CMS) and its intermediates any information needed to determine third party benefits payable for any services provided to me or my dependents by KCFD now or in the future.

Signature: _____ Date: _____ Signature: _____ Date: _____
Head of Household ***Spouse/Partner Signature***

Signature: _____ Date: _____ Signature: _____ Date: _____
Dependent Signature ***Dependent Signature***

Signature: _____ Date: _____ Signature: _____ Date: _____
Dependent Signature ***Dependent Signature***

KCFD Ambulance Services Membership Program Referral

Because we know how important the KCFD Membership Program is to you and your household members we hope that you take the opportunity to refer a friend or family member. Simply give us their information and we will do the rest.

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

One Team. One Job. One Mission.

For more information, questions or concerns please contact the Membership Department at (816) 924-1700.