MEMS*ALERT

APPLICATION – New Member

Name _____ **Birth Date** _____

Address _____ **SSN** _____

_____ **Phone** _____

City, State Zip _____ **Male or Female** (circle one)

Insurance Name **Insurance Address** **Policy or ID Number**

SUBSCRIPTION FEES

The category selected below must be true for all family members to be covered by this agreement. If family members have different levels of insurance coverage, the subscription fee will be based on the family member with the least amount of insurance coverage.

☐ **$60.00 Member with Primary (Medicare) and Supplemental** **Amount from left** _____

☐ **$70.00 Member with Primary Insurance (or Medicare) only** **Less $5 if renewing** _____

☐ **$80.00 Member with no Insurance** **Payment with application** _____

How did you hear about MEMS*Alert? ☐ **Newspaper** ☐ **Direct Mail** ☐ **Billboard** ☐ **Radio/TV** ☐ **Friend**

PAYMENT METHOD

☐ **Personal Check** (Please return with this application form. Make payable to: MEMS*ALERT)

☐ **Money Order** (Please return with this application form. Make payable to: MEMS*ALERT)

☐ **Visa or Mastercard** _____ **Expiration Date** _____

PLEASE DO NOT SEND CASH

AUTHORIZATION

A membership to MEMS Alert will cover co-payments and deductibles on all medically necessary emergency ambulance transportation. This membership also will cover co-payments and deductibles required by nonemergency ambulance transportation if that transportation is approved by member's insurance. For all other medically necessary services provided by MEMS, a 40% discount from billed charges will be provided.

I understand MEMS Alert is not an insurance policy. I authorize payment of insurance benefits for ambulance transportation directly to MEMS, 1101 W. 8th, Little Rock, AR 72203. I agree that a copy of this authorization is as effective as the original. I authorize any holder of medical information about me to release to CMS, its agents, Carriers, Social Security Administration, all other third party payors, and MEMS, any information or documentation in their possession needed to determine these benefits or the benefits payable for related services, now or in the future. I understand that this authorization can be revoked at any time by writing to MEMS and stating the desire to terminate this contract. I understand I am financially responsible to MEMS for charges not covered by this Authorization, and guarantee payment of all charges within 45 days from the date of service. I further agree that if collection is made necessary by lawsuit or otherwise, I agree to pay all collection costs including a reasonable attorney's fee.

Signature: _____ **Date:** _____

Medicaid recipients will have limited benefits from MEMS Alert. Ambulance transportation is fully covered by Medicaid.
MEMS*ALERT cannot be used for MEMS-Trans wheelchair van service. All subscriptions are non-refundable.

See other side for family member subscription information. Their signatures are also required.

ADDITIONAL FAMILY MEMBER INFORMATION

Please provide the following health insurance and family member information.
All members must live with the subscriber at the same street address as the subscriber.

FAMILY MEMBER 1

Name _____ **SSN** _____ **Birth Date**_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name **Insurance Address** **Policy or ID Number**

_____

_____

Signature: _____ **Date:** _____
By signing this document, I certify that I have read the Authorization agreement.

FAMILY MEMBER 2

Name _____ **SSN** _____ **Birth Date**_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name **Insurance Address** **Policy or ID Number**

_____

_____

Signature: _____ **Date:** _____
By signing this document, I certify that I have read the Authorization agreement.

FAMILY MEMBER 3

Name _____ **SSN** _____ **Birth Date**_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name **Insurance Address** **Policy or ID Number**

_____

_____

Signature: _____ **Date:** _____
By signing this document, I certify that I have read the Authorization agreement.

FAMILY MEMBER 4

Name _____ **SSN** _____ **Birth Date**_____

Relationship to Subscriber_____ **Male or Female?** (Please circle one)

Insurance Name **Insurance Address** **Policy or ID Number**

_____

_____

Signature: _____ **Date:** _____
By signing this document, I certify that I have read the Authorization agreement.