Tri-County Ambulance Association

Phone (541) 676-2932
Fax (541) 676-2901
PO Box 9
Heppner, OR 97836

(Please Print)
Last Name_____First_____M.I. ___

Mailing Address_____

City_____State_____Zip_____

Telephone _____Date of Birth_____Sex____

**List spouse and children under 21 living at home (**First name, middle initial, last name if different)

Spouse_____D.O.B._____Sex____

Name_____D.O.B._____Sex____

Name_____D.O.B._____Sex____

Name_____D.O.B._____Sex____

Name_____D.O.B._____Sex____

Name_____D.O.B._____Sex____

**YOUR ANNUAL PAYMENT IN THE AMOUNT OF $45 MUST ACCOMPANY THIS APPLICATION. Return to: Tri-County Ambulance Association**
**PO Box 9**
**Heppner, OR 97836**

I have enclosed payment by

( ) Cash
( ) Money Order
( ) Check

X_____
MEMBER'S SIGNATURE (I have read & agree to the statement on the reverse side)

# TRI-COUNTY AMBULANCE ASSOCIATION

COVERAGE BEGINS ON THE FIRST DAY OF THE MONTH FOLLOWING RECEIPT OF THE APPLICATION MATERIALS. COVERAGE EXTENDS FOR THE PERIOD OF ONE YEAR.

I understand that Tri-County Ambulance Association membership does not provide insurance coverage. Membership allows participating ambulance services (utilized by myself or a family member) to bill my insurance for any applicable medical benefits. I authorize the release of medical information for the purpose of ambulance insurance billing only. I agree that my membership covers myself and my immediate family. For the purposed of this agreement, immediate family is defined as any spouse and all unmarried children under the age of twenty-one living in my household./ Other family and/or non-family living in my household are considered a separate family and must obtain a separate membership.

I understand that Tri-County Ambulance Association will accept payment from my insurance companies as payment in full for covered services. Should I or a family member receive payment for ambulance service rendered, I will immediately forward the payment to the appropriate ambulance service organization. I also understand that I will be responsible for my own deductible (as defined by my insurances policies) and that I will be billed for any amounts applied against the deductible.

I understand that the $45 annual fee provides emergency pre-hospital medical care and ambulance transportation within the Tri-County region. These benefits are also provided with reciprocating ambulance organizations throughout Oregon. I understand that medically necessary ambulance services are covered by my membership and that I will not be billed for them. Some non-emergency services may also be covered—even when insurance coverage is denied. With Tri-County membership, I will not be billed for non-emergency transport as long as emergency personnel determine that this service is warranted. Emergency transfers between medical facilities will also be covered if authorized by a physician and medically necessary.

Non-emergency services NOT covered by this agreement are transport which can be pre-arranged. The following non-emergency transports are NOT covered by this agreement:

- Transfers to or from doctors' offices or clinics for routine appointment;
- Transfers to or from a nursing home to a doctor's office, clinic or hospital for treatment or routine care which is normally provided at the nursing home;
- Non-medically necessary transfers when other means of transportation could be used. Other means of transportation would be private vehicle, wheelchair van, taxi or other non-emergency vehicles. Example: transfer back home from the hospital after being checked and/or treated at the hospital if the patient's condition does not warrant an Emergency Medical Technician's care.

If I feel I must use an ambulance for non-emergency services and I insist upon transport against emergency personnel's determination of medical necessity, I understand that I will be billed by the ambulance organization for this service.

TO THE INSURANCE CARRIERS

I authorize payment of insurance benefits for ambulance service for myself and family members directly to the billing authority in accordance with the ambulance agreement and as itemized on submitted claims.

RECIPROCAL BILLING AGREEMENT

I authorize release of all information required for billing purposed to any ambulance provider that has an authorized reciprocal billing agreement with the Tri-County Ambulance Association. I further authorize any such ambulance provider from whom we have received service to directly bill their charges to my health insurance carrier.