MEMS ALERT

Metropolitan Emergency Medical Services - P.O. Box 2452 - Little Rock, AR 72203 - (501) 301-1423

September 5, 2016

Dear MEMS Alert Member,

It's that time of year to renew your subscription to MEMS Alert, MEMS' cost saving ambulance subscription program. This renewal will provide benefits for the November 1, 2016 – October 31, 2017 plan year.

This program protects you from unexpected ambulance charges if you require emergency medical care. The program also provides a reduced service fee for non-emergency service not covered by insurance or Medicare.

In order for you and your family to be eligible for MEMS Alert benefits, you must provide **all** of the information requested on the enclosed renewal form for **each** family member to be covered under your subscription. This information and a check, money order, or credit card must be mailed to MEMS Alert, P.O. Box 2452, Little Rock, AR 72203.

There are some people for whom MEMS Alert may not provide a benefit:

(1) Persons who are covered by Medicaid benefits. Medicaid pays 100% of transportation cost. MEMS Alert benefits will be limited to non-transportation services.

(2) Individuals whose health insurance pays for 100% of the cost associated with ambulance transportation. MEMS Alert benefits will be limited to non-transportation services.

(3) Persons living outside of MEMS service area. MEMS serves Pulaski County with the exception of the City of Jacksonville, Grant County, Faulkner County, and the City of Cabot in Lonoke County. If you do not reside in one of these areas, your 911 call will go to the EMS service with 911 response capabilities for your location. This is the ambulance service that can provide the fastest response to your emergency.

(4) If you miss the enrollment deadline of October 31, 2016, you may still submit an application, but you will not become a member until 30 days after we receive your full payment.

If you have any questions, please call (501) 301-1433.

Sincerely,
Metropolitan Emergency Medical Services (MEMS)

MEMS*ALERT 2016

APPLICATION – Renewal

SUBSCRIBER INFORMATION

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** ______________

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 72201. 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.

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.