



Crowley Fire Department EMS

A Service for the Community

Subscription Program Application

Date Received:
 Check – Check # _____
 Cash
 Credit Card – Confirmation # _____

Please complete all of the information listed below and **SIGN THE CONTRACT BELOW**. Return your completed form to the City of Crowley. If you have questions regarding this application please contact Crowley City Hall at (817) 297-2201. **ALL** requested information must be provided, **ALL** blanks must be filled in. **COMPLETE INSURANCE INFORMATION IS REQUIRED.**

DUE TO CURRENT REGULATIONS MEDICAID REPIENTS CANNOT PARTICIPATE IN THE SUBSCRIPTION PROGRAM

Please Print (Complete in Full)

HEAD OF HOUSEHOLD		Male		Female		I legally reside in Crowley Fire Department's Primary Service Area? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Last Name					First Name				MI	
Date of Birth		/ /			E-Mail Address					
Social Security Number					Medicare Number					
Home Address					City		ST.		Zip	
Mailing Address					City		ST.		Zip	
Home Phone	()	Cell Phone	()	Work Phone	()					
Employer Name					Employer Address					
Do you reside in a nursing home in the Crowley Fire Departments Primary Response Area? Yes <input type="checkbox"/> No <input type="checkbox"/>										
Names and Address of the facility										
Spouse Information		Male		Female		They legally reside in Crowley Fire Department's Primary Service Area? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Last Name					First Name				MI	
Date of Birth		/ /			E-Mail Address					
Social Security Number					Medicare Number					
Home Address					City		ST.		Zip	
Mailing Address					City		ST.		Zip	
Home Phone	()	Cell Phone	()	Work Phone	()					
Employer Name					Employer Address					
Does your spouse reside in a nursing home in the Crowley Fire Departments Primary Response Area? Yes <input type="checkbox"/> No <input type="checkbox"/>										
Names and Address of the facility										

Dependent Information (dependent qualifications are listed in the in the Subscription Brochure)

Male		Female		Last Name				First Name			MI.	
Relationship				Date of Birth	/ /		Age		Social Security Number			
Male		Female		Last Name				First Name			MI.	
Relationship				Date of Birth	/ /		Age		Social Security Number			
Male		Female		Last Name				First Name			MI.	
Relationship				Date of Birth	/ /		Age		Social Security Number			
Male		Female		Last Name				First Name			MI.	
Relationship				Date of Birth	/ /		Age		Social Security Number			
Male		Female		Last Name				First Name			MI.	
Relationship				Date of Birth	/ /		Age		Social Security Number			

Primary Insurance Information (Include copies of all Insurance Cards both sides)

Insurance Company: _____ Phone Number: _____
 Policy Number: _____ Group Number: _____
 Claims Mailing Address: _____

Secondary Insurance Information (Include copies of all Insurance Cards both sides)

Insurance Company: _____ Phone Number: _____
 Policy Number: _____ Group Number: _____
 Claims Mailing Address: _____

The Crowley Fire Departments EMS Subscription program is sponsored by the City of Crowley. The subscription program is designed to aid in offsetting the increasing cost of **EMERGENCY** ambulance treatment and transportation. Insurance companies routinely **DO NOT** pay the entire costs of **EMERGENCY** ambulance services leaving citizens with the responsibility of paying the balance of their emergency ambulance bill. The purpose of the subscription program is to cover the amount of an emergency ambulance bill which is not paid by your insurance provider or Medicare when you or a qualified family member is transported in an emergency event by the Crowley Fire Departments EMS Service. The subscription program is **NOT** an insurance policy or supplement. If you have any questions, please contact the Fire Department (817) 297-2201.

Covered Services

Emergency Transports are fully covered. An “emergency” is an unforeseen medical condition or traumatic injury which requires urgent and unscheduled medical attention, and the absence of such emergency treatment could place the patient’s health in serious jeopardy.

Excluded Services

Non-emergency transports are not covered, the Crowley Fire Department does not **OFFER or PROVIDE** non-emergency ambulance transport or transfer. A non-emergency medical transfer is defined as the patient is being transported for an on-going medical condition for which he/she is to be seen at the hospital/doctor’s office and/or requires transport to and from their residence or nursing facility. Transport from other providers. In the event the Crowley Fire Department does not have an emergency ambulance available to respond to your emergency and a mutual aid ambulance is called or should your condition warrant the utilization of an Air-Medical Helicopter. In these instances, the patient will be responsible for any bill which is incurred for the agency that provides transport.

Other Excluded Services

The following destinations are not included in coverage Doctors’ offices, dentist offices, physical therapy centers pharmacies. Also, not included are transports to destinations which are not in the Crowley Fire Department EMS’s service areas, along with response and assessment calls (i.e., care is given at the scene, but the patient was not transported). Emergencies originating outside of Crowley Fire Department’s initial response area, or transport from other agencies other than the Crowley Fire Department.

Who Can Participate

1. Residents of the City of Crowley and qualified family members who currently have medical insurance and/or Medicare.
2. Residents and their qualified family members who currently have medical insurance and/or Medicare and who live in the initial response area covered by the Crowley Fire Departments EMS.

Qualified Family Members

1. A legal spouse.
2. Children under the age of 26 who legally reside at your residence.
3. Other dependents listed on your tax return who legally reside at your residence.
4. A spouse or dependent child permanently living in a nursing care facility in the City of Crowley.

Qualified Family Exception:

In the event a family is caring for a disabled family member and that family member legally and permanently resides at your listed address an exception can be made; however, the disabled family member **CANNOT BE A MEDICAID RECIPIENT**, and they must have medical insurance and/or Medicare. Any exception must be approved by the Fire Chief and the City Manager exceptions will only be made on a case by case bases. **PROOF OF RESIDENCY IS REQUIRED**

Agreement, Acceptance, and Medicare Benefits Lifetime signature Authorization.

I accept the Crowley Fire Department EMS Subscription plan and in consideration and payment of the Subscription fee, I hereby; Assign to the City of Crowley, all ambulance benefits that I or any other family member may otherwise be entitled to receive from any insurance or other third-party payer for services provided under my Crowley Fire Department EMS Subscription. The City of Crowley will accept this assignment as payment in full for emergency ground transports. I understand that the City of Crowley will file my ambulance insurance claims for each covered person and is entitled to receive from all insurance or third-party payers up to the amount of Crowley Fire Department EMS’s usual charges. Any insurance from other third-party payment that I receive related to Crowley Fire Department EMS Services provided under my Crowley Fire Department EMS subscription shall be immediately forwarded to the City of Crowley. I authorize any holder of medical information about me or other qualified members to release to Advanced Data Processing, Inc, a subsidiary of Intermedix Corporation, and its agents and carriers as well as the Crowley Fire Department EMS, any information or documentation in their possession needed to determine those benefits payable for related services now or in the future.

By signing this application, I acknowledge the regulations for the Crowley Fire Department’s Ambulance Subscription Program. I understand all of the information listed in this application. By signing I am acknowledging that myself and all listed dependents are not **MEDICAID RECIPIENTS** and that all persons listed legally reside at the listed address which is in the Crowley Fire Department’s Primary Response Area.

Signature of the Head of Household

Date Signed