City of Riggins

Ambulance Subscription Membership

By becoming a member of the Riggins Ambulance Subscription Membership program, first, 100% of all money collected is returned to your local ambulance service. The Ambulance Subscription Membership Program is an official program of the City of Riggins. Additional funds beyond the subscription fee are considered to be a donation.

An ambulance transport can cost between $700 and $1200. Most insurance providers, including Medicare, expect you to pay 20% or more of the ambulance bill. Our program works like a supplement to your existing insurance or Medicare/Medicaid, or fills the financial gap if you don't already have insurance. As a member you won't have any surprise when it comes to your ambulance bill.

HOW THE SUBSCRIPTION PLAN WORKS (TERMS OF THE AGREEMENT)

1. When called, Riggins Ambulance will respond, examine, treat, and if medically necessary, transport you to one of our local hospitals (McCall or Grangeville). Your insurance, Medicare or Medicaid will be billed and if you are a subscriber to this low cost emergency service, fees not covered by your insurance are covered under the subscription. If you are not a subscriber, the usual fees for services rendered by Riggins Ambulance will be due and payable.
2. It does not cover any existing balances from prior ambulance transports.
3. Routine transfers from hospital to hospital, from home to hospital for non-emergency treatment, or to doctors' offices are not covered.
4. Subscription memberships are effective October 1st thru September 30th. Renewal is required each year.
5. Your Subscription Membership covers medically necessary emergency BLS (Basic Life Support) and ILS (Intermediate Life Support) calls. It does not cover helicopter rides and/or private ambulance transports.
6. All emergency calls resulting in a transport by Riggins Ambulance are covered.
7. Patients who are not members of the Ambulance Subscription will be billed for any outstanding balance not covered by their insurance.
8. Some insurance companies send payments for ambulance transport services directly to the patient, who is then responsible to pay the bill. If this happens, please forward the payment immediately to:

   City of Riggins
   P.O. Box 249
   Riggins, ID 83549

9. When a subscriber moves out of the area covered by Riggins Ambulance, the subscription is void.
10. Subscription memberships cover only the resident residing at the home unless you have a family membership.
11. You can enroll in the program at any time. Coverage begins 48 hours after the date we receive your application and payment and expires on September 30th.
12. Subscriptions are not pro-rated. If you signup part way thru the year, you pay the full year subscription fee.
13. Family coverage extends to any unmarried dependent children under the age of 25 or other dependents that have court documented guardianship papers.
14. This application supplies needed insurance information to expedite billing.
15. The subscription is non-refundable.
16. Violations of the terms of the agreement or false information entered on the subscription application may result in immediate cancellation of the subscription.

City of Riggins
Ambulance Subscription Membership Program Agreement

READ THE STATEMENT CAREFULLY AND SIGN AND DATE APPLICATION

I hereby apply for subscription services for myself (or family) at my address within the Riggins Ambulance service area and I declare that I am a resident of this area.

I understand that the annual fee provides ambulance ***(emergency only)*** *service provided by Riggins Ambulance, as often as needed.*

This service will be provided at no cost to subscriber, from 48 hours after the day the subscription became effective through September 30th.

I also understand that the coverage is in excess of any insurance or medical benefits, which I may have, and I authorize the release of medical information for the purpose of ambulance insurance billing only.

Should I receive payment by insurance or medical benefits provided for ambulance service rendered, I will immediately forward such payment to the City of Riggins.

*This subscription is nontransferable***.**

I HAVE READ THE ABOVE AGREEMENT AND UNDERSTAND THE TERMS:

Signature: _____Date:_____

You will need to check with your current medical insurance company to verify if a co-pay is required. If your medical insurance does not require a co-pay for ambulance transportation, this program would not be beneficial to you.

Mail the application and payment to:

City of Riggins
P.O. Box 249
Riggins, ID 83549

Or drop off the application and payment at Riggins City Hall.

City of Riggins
City Hall
126 N Main
Riggins, ID 83549

City of Riggins

AMBULANCE SUBSCRIPTION MEMBERSHIP APPLICATION

Please complete and sign below. Incomplete or unsigned applications will be returned.

Applicant Information

Last Name		First Name	Middle Initial	M/F
Street Address:		City, State, Zip Code	Phone Number ( )	
Mailing Address:				
Date of Birth	Social Security #		Alternate Phone Number ( )	
Primary Insurance Company or Medicare Information				
Insurance Name		Policy #	Group #	Phone Number ( )
Claims Mailing Address	City	State	Zip Code	
Secondary Insurance Information				
Insurance Name		Policy #	Group #	Phone Number ( )
Claims Mailing Address	City	State	Zip Code	

____ Individual Membership $100.00 (October 1 thru September 30)

____Individual Lifetime Membership $1,000.00

____ Family Membership $100.00 (October 1 thru September 30)

Spouse or Dependent Information

Last Name		First Name	Middle Initial	M/F
Street Address		City, State, Zip Code	Phone Number ( )	
Date of Birth	Social Security #		Alternate Phone Number ( )	
Primary Insurance Company or Medicare Information				
Insurance Name		Policy #	Group #	Phone Number ( )
Claims Mailing Address	City	State	Zip Code	
Secondary Insurance Information				
Insurance Name		Policy #	Group #	Phone Number ( )
Claims Mailing Address	City	State	Zip Code	

Dependent Information

Last Name		First Name		Middle Initial	M/F
Street Address		City, State, Zip Code		Phone Number ( )	
Date of Birth	Social Security #			Alternate Phone Number ( )	
Primary Insurance Company or Medicare Information					
Insurance Name		Policy #	Group #	Phone Number ( )	
Claims Mailing Address		City	State	Zip Code	
Secondary Insurance Information					
Insurance Name		Policy #	Group #	Phone Number ( )	
Claims Mailing Address		City	State	Zip Code	

Dependent Information

Last Name		First Name		Middle Initial	M/F
Street Address		City, State, Zip Code		Phone Number ( )	
Date of Birth	Social Security #			Alternate Phone Number ( )	
Primary Insurance Company or Medicare Information					
Insurance Name		Policy #	Group #	Phone Number ( )	
Claims Mailing Address		City	State	Zip Code	
Secondary Insurance Information					
Insurance Name		Policy #	Group #	Phone Number ( )	
Claims Mailing Address		City	State	Zip Code	

Your support is greatly appreciated.
On behalf of the City of Riggins and Riggins Emergency Medical Services,

"THANK YOU"

for your very generous contributions!