BACK MOUNTAIN REGIONAL EMS

You may complete this information for your records:

Date Sent _____ Amount $ _____ Check No. _____

123456 Please refer to this number in any correspondence.

Crews staffed 24 hours a day,
365 days a year!

SAMPLE NAME
APT 101
12345 MAIN STREET
SOUTH PARK PA 15129

T000

00000 123456

Please send your donation today!

Subscription Receipt

• 2020-2021 •

KEEP THIS PORTION FOR YOUR RECORDS

ALL EMERGENCY CALLS:

9 - 1 - 1

INFORMATION CALLS ONLY:

570-675-0636

WWW.BKMTREGIONAL.COM

Detach Here

BACK MOUNTAIN REGIONAL EMS

Circle the amount of your Subscription & return this portion.

HOUSEHOLD	OTHER AMOUNT
$30.00	$_____

123456 Please refer to this number in any correspondence.

Please Make Any Necessary Corrections To Name & Address Below

SAMPLE NAME
APT 101
12345 MAIN STREET
SOUTH PARK PA 15129

• 2020-2021 •

Subscription Request

Make Checks Payable To:

BACK MOUNTAIN REGIONAL EMS
PO BOX 41
DALLAS PA 18612

[_]-PLEASE CORRECT NAME
[_]-SEND VOLUNTEER INFORMATION

E-mail Address:_____

RETURN THIS PORTION IN THE ENVELOPE PROVIDED

Detach Here

1

!!!WE NEED YOUR HELP!!!

Enclosed is your 2020-2021 Subscription Card. **Why should I subscribe?** The answer is in the following example:

Cost of average ambulance call:	$800.00
Avg. Insurance reimbursement:	$400.00
Balance due to ***Back Mountain Regional EMS:***	$400.00
Subscriber pays:	$ 0.00
Non-Subscriber pays:	$400.00

2918

Please detach this card after mailing us your subscription fee.

SUBSCRIPTION CARD

BACK MOUNTAIN REGIONAL EMS

SAMPLE NAME
123456

EMERGENCY CALLS **9 - 1 - 1**

ALL OTHER CALLS 570-675-0636

EXPIRES June 30th, 2021

REMOVE AND RETAIN SUBSCRIPTION CARD

Authorization

I understand that I am financially responsible for the services provided to me or my family members by this health service provider or supplier regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the health service provider or supplier or its billing agent for any services provided to me by the health provider or supplier. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Service and its carriers and agents, as well as to the health provider or supplier and its billing agents, any information or documentation needed to determine these benefits payable for any services provided to me by the health service provider, both now or in the future. A copy of this form is as valid as the original. I also agree to immediately remit to the health service provider any payments that I receive directly from any source for the services provided to me.

Signature_____ **Date** _____

Please list all family members residing at this address to be covered by this membership. **Date of Birth**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Remember: Always wear your seat belt and make sure children are properly secured.

This membership entitles the holder unlimited **Emergency Medical Service** within the coverage area, subject to the subscription terms and conditions, available upon request.

-THANK YOU FOR YOUR SUPPORT-