STOREY COUNTY FIRE PROTECTION DISTRICT

Ambulance Subscription Application

Subscription activates on the first day of the month following receipt of application and payment. Membership is effective for ONE YEAR.

Choose your coverage:	☐ Single $75	☐ Household $125

Household Information

Phone Number		Email			
Home Address					
City		State		Zip Code	
Mailing Address (If different)					
City		State		Zip Code	

Contact Information

	First Name	Last Name	Date of Birth
Primary Member			
Additional Member			
Additional Member			
Additional Member			
Additional Member			
Additional Member			
Additional Member			

☐ I AM CURRENTLY UNINSURED. I understand that I will be subject to a $200 Co-Payment per service for the first two services and full charges for every service thereafter. (INITIAL IN BOX)

Would you like to give a donation to Storey County Fire? $

Payment Information

☐	CHECK ENCLOSED – Payable to Storey County Fire Protection District
☐	CASH – In person
☐	CREDIT CARD – Complete information below

Name on card			
Card number			
Expiration date		Security code	

All forms must have a signature and be accompanied with payment before processing.

Primary Member Signature:	**Date:**

Please complete and return this form along with your membership fee to:

145 N. "C" St.

P.O. Box 603

Virginia City, NV 89440

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QUESTIONS?

Call (775) 847-0954

This is not an application for an insurance policy.

- I understand that the **subscription period** for the Program is from 12:01am on July 1 of each year to and including 12:00am on June 30 of the following calendar year. If my application is received any other time than open enrollment, my coverage will begin two weeks after the date my application and fee are received and recorded, to the end of the subscription period for that year with no pro-rating of my subscription fee.
- I understand that this subscription will be **renewed** each year only by my payment of the subscription fee in effect at the time of open enrollment, my confirmation of insurance and contact information on file, and my signature on the current renewal agreement.
- I understand that my Ambulance Subscription is **non-transferable and non-refundable**, and will be forfeited if I move out of or cease to be employed in Storey County.
- I understand that my subscription covers my portion of SCFPD's services that are applied to co-insurance or deductibles by insurance for medically necessary transports. **"Medically necessary"** is defined as specific need of ambulance transportation to the nearest medically appropriate hospital as requested by a physician or as directed by state/county protocols. The absence of alternative methods of transport does not, by itself, constitute medical necessity. SCFPD reserves the right to require physician certification of medical necessity.
- I understand that only transportation initiating from within **SCFPD's service area** will be covered by the Program. Destination shall be governed by existing medical protocols. I will be responsible for any costs incurred by transport to a location not covered by the Program.
- I understand that the Program benefits only apply when a member is transported by SCFPD or a reciprocating program (see list of current programs on our website)
- I understand that Program membership **does NOT cover** the services of other 911 providers, REMSA or SEMSA's ground ambulance, or any **air-flight ambulance** service, including but not limited to mutual aid situations.
- I understand that SCFPD Ambulance Subscription Program **is NOT an insurance policy nor is it meant to be a substitute for health insurance.** I agree that if I have no insurance, or if my insurance company denies payment to SCFPD because it determines that my ambulance services were not payable, I will be responsible for a two hundred dollar ($200) copayment for the first two services and full charges for every service thereafter.
- I understand that any **newly added membership** must be recorded for a minimum of two-weeks prior to the use of SCFPD services to be effective.
- I understand that my Subscription covers those persons who are **permanently residing in my household** and who are listed on my application. A "household" is defined as all persons who permanently reside at the named "Head of Household's" physical address listed on the Membership Application.
- I understand that if I am a **non-resident employee** in Storey County, I am covered only during working hours and during travel to and from work for transportation initiating from within SCFPD's coverage area.
- I understand that my membership may be cancelled at any time for any reason.
- **ELIGIBILITY**: I understand that Medicaid/Med-Cal recipients (due to their own policies), anyone with outstanding bills for past SCFPD services, anyone who does not reside or work within Storey County, anyone whose subscription was terminated due to abuse of the Program, residents of medical/assisted living establishments, corporations, partnerships, associations, and all other organizations of people are NOT eligible for Ambulance Program membership. I verify that I am not included in any of these listed ineligible groups.
- **ASSIGNMENT OF BENEFITS**: I understand that my membership is not an insurance plan and that SCFPD will bill and receive payments from my insurer or third party (such as Medicare). I hereby authorize all benefits to be paid directly to SCFPD. If I have Medicare, I request that payment or authorized Medicare benefits be made on my behalf to SCFPD for any ambulance service provided to me by SCFPD. If I receive payment from my insurance company or Medicare, I will immediately forward that payment to SCFPD. If I do not, I understand that my membership may be terminated and I will be billed full charges for SCFPD services. I acknowledge that I am responsible for payment of ambulance services.
- **LIFETIME SIGNATURE AUTHORIZATION**: To facilitate processing, I authorize the release to the Centers for Medicare and Medicaid Services and/or other insurer of any medical information or documentation held by anyone necessary to process a claim now or in the future, and further assign and authorize such payments to SCFPD. I permit a copy of this authorization to be used in place of the original.

*SCFPD reserves the right to **cancel** and refund a prorated portion of the Subscriber's enrollment fee based upon the un-expired enrollment period if, in the opinion of the Board of Commissioner's of Virginia City, the operation of this Agreement is no longer in the best interest of the county. SCFPD will notify all Subscribers through regular mail at least thirty (30) days prior to canceling this Agreement.*

Every person over the age of 18 must sign this application form. Application for persons under 18 should be signed by their guarantor.
SCFPD is compliant with HIPAA regulations. A copy of our Notice of Privacy Practices is available on request.
This agreement and application/renewal forms may be found on our website.

Storey County Fire Protection District – Ambulance Subscription Program - PO Box 603 (145 N. C Street) - Virginia City, NV 89440
Phone 775.847.0954 - Fax 775.847.0987 - www.storeycounty.org [Fire Department] [Community Programs]