SUNSTAR FirstCare Ambulance Membership

Application and Agreement - 2019

Member Information		
Please read Membership Agreement on reverse prior to signing **The application must be signed by all members 18 years of age and over**		
Primary Member #1 Full Name and Address:	**Social Security #:**	**Birth Date:**
	Email Address:	
Member #1 Signature: Must be signed	**Date Signed:**	**Phone#:**

Insurance Information		
Primary Insurance Name:	**ID/Contract#:**	**Group#:**
Secondary Insurance Name:	**ID/Contract#:**	**Group#:**

Additional Family Members		
Family Member #2 Name:	**Social Security #:**	**Birth Date:**
Primary Insurance Name:	**ID/Contract#:**	**Group#:**
Member #2 Signature: Must be signed	**Date Signed:**	**Phone#:**
Family Member #3 Name:	**Social Security #:**	**Birth Date:**
Primary Insurance Name:	**ID/Contract#:**	**Group#:**
Member #3 Signature: Must be signed	**Date Signed:**	**Phone#:**
Family Member #4 Name:	**Social Security #:**	**Birth Date:**
Primary Insurance Name:	**ID/Contract#:**	**Group#:**
Member #4 Signature: Must be signed	**Date Signed:**	**Phone#:**

Payment Information

FOR YOUR SECURITY, CREDIT CARD PAYMENTS ARE NO LONGER ACCEPTED BY MAIL.
If you would like to pay by credit card please submit a completed application. A customer service representative will contact you to process the credit card transaction over the phone.

Please check one:	☐ **$103.00 Family**	☐ **$68.00 Single**
☐ **Credit Card by Phone**	**Check #:**	**Money Order#:**

RETURN THIS FORM WITH CHECK OR MONEY ORDER

*****Use a separate piece of paper to add additional family members and/or additional insurance information*****

For more information, please visit our website at: http://www.pinellascounty.org/FirstCare

Or contact our office at (727) 582-2008

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ENROLLMENT FEE: I acknowledge that I am responsible for the payment of ambulance services provided to me by Sunstar and my Membership fee for the Sunstar FirstCare Ambulance Membership covers my copayments and deductibles. If my claim is denied by my active insurance at the time of ambulance service(s), the Membership covers 50% of my ambulance bill. **If I DO NOT have active insurance, including Medicare or Medicaid**, the Membership covers **20%** of my ambulance bill. Annual Membership fees: Single Person Membership is **$68**; Family Membership is **$103**. Please make check or money order payable to Sunstar and mail check with your completed application to: Sunstar at P.O. Box 31074, Tampa, FL 33631-3074.

COMPLIANCE WITH SECTION 119.071 (5), FLORIDA STATUTES REGARDING COLLECTION AND USAGE OF YOUR SOCIAL SECURITY NUMBER: Pursuant to requirements outlined in Florida Statutes Section 119.071 (5), OTHER PERSONAL INFORMATION, we are hereby advising you that the collection of your social security number is imperative for the performance of the billing and insurance verification processes. Your Social Security Number will be used for billing purposes and to enable other healthcare providers and/or insurers to identify your applicable records.

MEMBERSHIP COVERAGE: The Membership covers ambulance transports within the Pinellas County "locality" by Sunstar ambulance units only. "Medicare definition of "Locality": *"with respect to ambulance service means the service area surrounding the institution to which individuals normally travel to receive hospital or skilled nursing services"*. The Membership does not cover transports via Sunstar's Mental Health Transport Van.

ELIGIBLE FAMILY MEMBERS: The Family Membership covers family members related by blood, adoption, or marriage who permanently reside in the same household as the primary member.

ASSIGNMENT OF INSURANCE BENEFITS: I acknowledge that I am responsible for paying ambulance services provided to me by Sunstar, except those eligible under the Membership. I acknowledge that Sunstar will file claims on my behalf with my primary and secondary (if applicable) insurance carrier(s) including Medicare. I herein assign my right to reimbursement for covered transports to Sunstar.

INSURANCE PAYMENT OF CLAIMS: I authorize payment resulting from claims billed on my behalf be made directly to Sunstar. In the event I receive payment directly from my insurance company related to the transport, I agree to endorse the check, include explanation of benefits and mail to: Sunstar at P.O. Box 31074, Tampa, FL 33631-3074. If I do not forward the payment to Sunstar, I understand I will receive a bill and be responsible for the payment of this amount.

RELEASE OF MEDICAL INFORMATION: As a part of the billing process, I authorize release of any holder of medical information about me or other relevant documentation about me to release to Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contracts, as well as Sunstar, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related service, whether in the past, now or in the future.

EFFECTIVE DATES: **NEW MEMBERSHIPS:** Completed applications with payment in full, received prior to the end of the calendar year, will be effective on January 1st. Completed applications with payment in full received after January 1st, will be effective on the postmark date. **RENEWALS:** Completed applications with payment in full (received prior to April 1st) will be effective April 1st. All memberships expire on March 31st of the following year. **Members whose applications are received or postmarked after March 31st will not have coverage for the full 12-month period and Membership fees will not be pro-rated.**

REFUNDS: I acknowledge that Membership fees are non-refundable and are used to cover the cost of administering the Membership and processing my application. I am therefore not entitled to any refund of monies paid to Sunstar under this agreement after the agreement's effective date. Membership is not transferrable.

NEED FOR MEMBERSHIP COVERAGE: If I have medical insurance, I acknowledge that I have reviewed my coverage as it pertains to ambulance transportation and have made a voluntary determination to enroll in the Membership, as some insurance carriers cover 100% of ambulance transportation.

PROOF OF MEMBERSHIP: Your check or credit card statement is your receipt. Membership cards are unnecessary, and are not issued. If you are transported, your Membership will be verified by Sunstar.

BY SIGNING THE MEMBERSHIP APPLICATION & AGREEMENT, I AGREE TO ABIDE BY THE TERMS HEREOF.