# SeniorCare Membership Plan

Please complete this form and submit with payment at by mail to the following:

Falck Mobile Health Corp.
ATTN: SENIORCARE 911 AMBULANCE MEMBERSHIP
1517 W. Braden Court, Orange, CA 92868

## PRIMARY MEMBER:

FULL NAME: DATE OF BIRTH:

ADDRESS: PHONE NUMBER:

CITY: ZIP CODE:

EMAIL: SSN:

PRIMARY INSURANCE: MEDICARE #:

SECONDARY INSURANCE:

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## 2ND MEMBER:

FULL NAME: DATE OF BIRTH:

ADDRESS: PHONE NUMBER:

CITY: ZIP CODE:

EMAIL: SSN:

PRIMARY INSURANCE: MEDICARE #:

SECONDARY INSURANCE:

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## 3RD MEMBER:

FULL NAME: DATE OF BIRTH:

ADDRESS: PHONE NUMBER:

CITY: ZIP CODE:

EMAIL: SSN:

PRIMARY INSURANCE: MEDICARE #:

SECONDARY INSURANCE:

**PAYMENT DUE: $80.00**

PRINT APPLICATION AND MAIL FORM TO:

FALCK MOBILE HEALTH CORP
ATTN: SENIORCARE 911 AMBULANCE MEMBERSHIP
1517 W. BRADEN CT.
ORANGE, CA 92868

By filling out this application form, I certify that I have read a Statement of Understanding and I agree to the terms of the Membership.

PRIMARY SIGNATURE:

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Falck Mobile Health Corp. now, in the past, or in the future, until such time as I revoke this authorization in writing.

I understand that I am financially responsible for the services and supplies provided to me by Falck Mobile Health Corp., regardless of my insurance coverage and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Falck Mobile Health Corp any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Falck Mobile Health Corp. I authorize Falck Mobile Health Corp. to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing, or other relevant information about me to release such information to Falck Mobile Health Corp. and its billing agents, the Centers for Medicare and Medicaid Services, and/or any payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Falck Mobile Health Corp., now, in the past, or in the future. I also authorize Falck Mobile Health Corp. to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

I agree, in order for Falck Mobile Health Corp. to service their account to collect any amounts I may owe, Falck Mobile Health Corp. may contact me by telephone, at any telephone number associated with my account or to collect any amounts I may owe. Falck Mobile Health Corp. may also contact me by sending emails, using any email address I provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

Privacy Practices Acknowledgment: by signing below, I acknowledge that Falck Mobile Health Corp. provided a copy of its Notice of Privacy Practices to me. *A copy of this form is valid as an original*

Remaining Member Signatures (All Members associated w/ Membership must sign):

FULL NAME: SIGNATURE/DATE:

FULL NAME: SIGNATURE/DATE:

**IMPORTANT NOTICE- PLEASE READ AND INITIAL BEFORE PURCHASING MEMBERSHIP**

If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by an Ambulance Plan may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly.

WARNING: This Ambulance Plan is not an insurance program. It will not compensate or reimburse another ambulance company that provides emergency transportation to you or your family. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service or is next in the rotation to receive a call. This might also occur when this Ambulance Plan is unable to perform within a medically appropriate timeframe due to a mechanical or maintenance problem or being on another call.

**Sign or Initial Here**

COMPLAINTS: For complaints regarding this Ambulance Plan, first attempt to call the plan at (844) 401-4732. If the Ambulance Plan fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1-888-466-2219. The Department's website is http://www.healthhelp.ca.gov. You may obtain complaint forms and instructions online."

OPERATING UNDER CONDITIONAL EXEMPTION: This Ambulance Plan is operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq.).