

**PARAMEDIC AMBULANCE MEMBERSHIP PLAN
(PAMP)**

CENTRAL EMS

645 S. School Ave. Fayetteville, AR 72701
521-5801 or 267-5805

Annual Membership Dues: **\$85 with Insurance** or **\$100 without Insurance**.

First Name: _____ Middle Name: _____ Last Name: _____

Physical Address: _____

City: _____ State: _____ Zipcode: _____

Primary Phone: _____ Alternate Phone: _____

(check if mailing address same as physical address)

Mailing Address: _____

City: _____ State: _____ Zipcode: _____

Please List All Family Members Living in the Household (Only household family members are covered):

Name	Date of Birth	Social Security #	Relationship

Health Insurance Name	Health Insurance Address	Insured's Name (name as appears on Ins Card)	ID / Policy Number

Your signature below indicates you have read and agreed to the terms of membership.

Terms: I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Central EMS now, in the past, or in the future, until such time as I revoke this authorization in writing. If I receive any payment for Ambulance Service, I agree to pay this to Central EMS. PAMP will then pay any charges that may be due. If I do not pay Central EMS any insurance payment received, I understand that my membership becomes void, I will owe the total charges, and my membership dues will be non-refundable. If my insurance does not cover my transport, PAMP will pay one-half of the charges.

Privacy Practices Acknowledgment: by signing below, the signer acknowledges Central EMS provided a copy of its Notice of Privacy Practices to the patient or other party, along with instructions to provide the Notice to the patient.

Payment Methods accepted: **CHECK, CASH, MONEY ORDER or ONLINE PAYMENT**

Make your check payable to PAMP and return to the above address. Membership starts on the first day of the first month **after** we receive your application **and** payment in our office.

Applicant Signature: _____ Date: _____