Sheridan Fire District
FireMed Membership Application

PO Box 6
Sheridan, OR 97378

Annual Membership: November 1 – October 31

$60 per family*

Primary Member

Last Name:______________________________ First Name:________________________ Initial:_____

Street Address:____

Mailing:(if different)____

City:________________________________ State:___________________ Zip:_____________________

Primary Telephone:____________________________ Secondary Telephone:______________________

Date of Birth:___________________________ Female_____ Male_____

Other Household Members **(including unmarried children living in the household under age 21 & they are your dependents)**

	Last Name	First Name	MI	Date of Birth	Relationship
1.					
2.					
3.					
4.					
5.					
6.					

Please read the Sheridan Fire District FireMed Agreement on the reverse side.

Please complete and sign this form, and return along with your payment. This Form must be signed by all persons in household covered by this membership between the ages of 18-21.

Primary Member

X_____________________________________

Household Members (ages 18-21 must sign)

X_____________________________________

X_____________________________________

X_____________________________________

X_____________________________________

Date Rcvd________________________

Check #__________________________

Cash____________________________

Receipt #_________________________

X________________________________

FireMed Agreement

Please read this statement carefully, and then sign the application on the front.

The FireMed Ambulance Membership Program is a voluntary service available to residents living within the Sheridan ambulance service area. I hereby apply for a FireMed membership for myself, and my dependent Family/household members* who live at my address for the FireMed fiscal year. I understand that the membership fee provides medically necessary** pre-hospital care and ambulance transportation within the FireMed reciprocal areas.

Should I, or any of my dependent family/household members be transported by ambulance under the FireMed Agreement, I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to my ambulance supplier for any services provided to us past, present or future. I understand that this authorization may be used by the supplier for all services until such time that I revoke this authorization in writing. I agree to immediately remit to my ambulance supplier any payment that I receive directly from insurance or any source whatsoever for the services provided to me or my family and I assign all right to such payments to my ambulance supplier. I authorize appeals of payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to my ambulance supplier and its billing agents, and/or the Centers for Medicare and Medicaid services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by my ambulance supplier, now or in the future. I understand that I may get a copy of my ambulance suppliers Notice of Privacy Practices at the local office. A copy of this form is as valid as the original.

I understand that medical transportation is based on medical necessity, not on membership status, and that patients will be transported to the closest medically appropriate facility.

I understand that my membership covers only ambulance transports in our reciprocal area, which are medically necessary and does not cover the wheel chair car or transfers of any kind.

I understand that FireMed is not insurance, but will provide service through the FireMed reciprocal agencies. FireMed will bill whatever insurance or medical benefits I may have and is entitled to primary and secondary insurance payment. FireMed is in excess of any insurance or medical benefits which I may have.

I transfer, directly to the provider of service, my rights to insurance payment from my primary and secondary insurance carrier as payment in full. Such payment shall not exceed regular charges. Should a family member or I receive payment from insurance or other medical benefits provider for ambulance services rendered by a FireMed Reciprocal Agency, I will immediately forward such payment to the provider of service.

I further authorize the release of medical information for the purpose of ambulance insurance billing only. FireMed membership is not intended to solicit Medicaid enrolled patients, and such membership constitutes a voluntary contribution only.

I understand that violations of the terms of this agreement may result in immediate cancellation. This membership is non-refundable, non-transferable and non pro-rated.

I also understand that my $60 fee is non tax deductible.

New member benefits take effect after receipt of completed application and payment, plus 2 days, if enrolled outside of open enrollment (Sept. 1 – Oct. 31).

*Definition of family:

FireMed membership covers immediate family members living in the same household. The members, spouse, unmarried children under age 21 and other persons listed as legal dependents for income tax purposes are covered. Others not included in this definition are required to obtain their own separate membership.

**Definition of medically necessary:

Medical necessity is satisfied when the "lack of transport" could place the patient's health in serious jeopardy, could cause impairment of bodily functions, or another mode of transportation could endanger the health of the patient.

Call or visit the administrative office with any questions

Sheridan Fire District
230 SW Mill St., Sheridan, OR 97378
503-843-2467
www.sheridanfd.org