APPLICATION FOR

CHINCOTEAGUE VOLUNTEER FIRE COMPANY, INCORPORATED

2023 ANNUAL AMBULANCE FAMILY PLAN

Dear Subscriber:

Your annual Ambulance Family Plan is due on January 1, 2023. The cost of this plan is $96.00 per year (pro-rated monthly). The plan covers all members of your family that you claim on your ***FEDERAL INCOME TAX***. Please ensure you fill out both pages on the accompanying form. We will bill your insurance and write off any remaining charges that your insurance does not pay. If you do not have any insurance, **you will not be billed**.

This plan covers EMERGENCY Service to:

- Service to Riverside Shore Memorial Hospital, Onley, VA.
- Service to Tidal Health Regional Medical Center, Salisbury, MD.
- Service to Atlantic General Hospital, Berlin, MD.
- Service to McCready Hospital, Crisfield, MD.

Mail the completed application to:

Chincoteague Volunteer Fire Company, Inc.
ATTN: Annual Ambulance Family Plan
PO BOX 691
Chincoteague, Virginia 23336

If you desire additional information, please contact us at 757-336-6055. If there is no answer, please leave a message on the answering service and someone will return your call as soon as possible.

Sincerely,

Billy Joe Tarr
Treasurer

Please list yourself and your dependent and send with your annual fee:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS: TELEPHONE NUMBERS:

______________________________ ______________

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IF ANY OF THE FOLLOWING HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INCIDATE...

ABOUT YOU:

YOUR NAME (Last, First, Middle Initial)			
ADDRESS			
CITY		STATE	ZIP
TELEPHONE		MARITAL STATUS ☐ Single ☐ Married	☐ Separated ☐ Divorced ☐ Widowed
EMPLOYER'S NAME		TELEPHONE	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP

ABOUT YOUR INSURANCE:

YOUR PRIMARY INSURANCE COMPANY'S NAME	EFFECTIVE DATE	
PRIMANY INSURANCE COMPANY'S ADDRESS	TELEPHONE	
CITY	STATE	ZIP
POLICY HOLDER'S ID NUMBER	GROUP PLAN NUMBER	
YOUR SECONDARY INSURANCE COMPANY'S NAME	EFFECTIVE DATE	
SECONDARY INSURANCE COMPANY'S ADDRESS	TELEPHONE	
CITY	STATE	ZIP
POLICYHOLDER'S ID NUMBER	GROUP PLAN NUMBER	

Medicare Patients
If you qualify under Medicare Part B please contact our Account Services Department. We file and accept assignment on covered and medically necessary Medicare Part B claims.

Medicaid Patients
Non-Emergency transports require prior approval from Medicaid. You are responsible for the bill if Medicaid denies the claim for ineligibility and non-covered services. Contact our Account Services Department if you are eligible under Medicaid.

Other Insurances
If you have health insurance for the payment and all deductibles, co-payments, balances, or denied claims as allowed under applicable State and Federal statutes.

Lifetime Assignment of Claim and Authorization – PROVIDE INSURANCE INFORMATION
I request that payment of authorized Medicare, Medicaid and/or commercial insurance benefits be made either to me or on my behalf to Chincoteague Volunteer Fire Company, Inc. for any service furnished to me by that supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its billing agents and carriers as well as to Chincoteague Volunteer Fire Company, Inc. any information or documentation needed to determine these benefits or the benefits payable for related services provided to me, and I assign all rights to such payments to Chincoteague Volunteer Fire Company, Inc. I authorize Chincoteague Volunteer Fire Company, Inc. to appeal payment denials or other adverse decisions on my behalf without further authorization. I understand that this authorization may be used by the supplier for all services now, in the past, and in the future until such time as I revoke this authorization in writing. A copy of this form is as valid as an original.

Signature: ____ Date: _______________