Emergency Treatment and Transport
Subscription Program Application

Please indicate the subscription you are applying for:

Single	**$35.00**		**Uninsured Single**	**$50.00**	
Family	**$50.00**		**Uninsured Family**	**$75.00**	
Senior Single	**$25.00**		**Non Students 18+**	**$15.00**	
Senior Couple	**$40.00**		**Long Distance Transfer**	**$10.00**	

Family/Single/Senior Billing Information: ***Please Print***

Last Name:	**First Name:**	
Street Address:	**City:**	**State: Zip:**
Phone: ( )	**e-mail:**	

Family/Single/Senior: ***Please Print***

Name		Date of Birth	Social Security #	M	F
Adult 1		/ /	- -		
Adult 2		/ /	- -		
Dependent		/ /	- -		
Dependent		/ /	- -		
Dependent		/ /	- -		
Dependent		/ /	- -		
Dependent		/ /	- -		
Dependent		/ /	- -		

Insurance Information

Primary Insurance: ***Please Print***

Insurance Company Name:	
Billing Address:	
ID#:	**Phone:**
Group #:	

Secondary Insurance: ***Please Print***

Insurance Company Name:	
Billing Address:	
ID#:	**Phone:**
Group #:	

By signing this form, I hereby authorize any holder of medical information or documentation about me or my family members listed above to release to Enable Billing and its agents and carriers, third party payers and insurers, and Morgan County Ambulance Service any information or documentation needed to process my insurance claim for service provided by Morgan County Ambulance Service, now and in the future. I further authorize direct payment of any insurance benefits to Morgan County Ambulance Service and its agents, and agree to forward any medical insurance benefits received by me to Morgan County Ambulance Service. I also, agree to all terms as stated in the MCAS Emergency Transport Membership Policy.

Name of Policy Holder: ***Please Print***

Signature of Policy Holder:	**Date:**

Thank you for your membership and for supporting Morgan County Ambulance Service

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Business	**$75.00 plus 2.00/employee**	
Total		

Billing Information: ***Please Print***

Business Name:		
Last Name:	**First Name:**	
Street Address:	**City:**	**State: Zip:**
Phone: ( )	**e-mail:**	

Employee Information: ***Please Print***

	Employee Name	Date of Birth	Social Security Number	M	F
1		/ /	- -		
2		/ /	- -		
3		/ /	- -		
4		/ /	- -		
5		/ /	- -		
6		/ /	- -		
7		/ /	- -		
8		/ /	- -		
9		/ /	- -		
10					

Insurance Information

Primary Insurance: ***Please Print***

Insurance Company Name:	
Billing Address:	
ID#:	**Phone:**
Group #:	

Secondary Insurance: ***Please Print***

Insurance Company Name:	
Billing Address:	
ID#:	**Phone:**
Group #:	

Name of Policy Holder: ***Please Print***

Signature of Policy holder:	**Date:**

By agreeing to be added to this list, I hereby authorize any holder of medical information or documentation about me to release to Enable Billing, its agents and carriers, third party payers, insurers, and Morgan County Ambulance Service any information or documentation necessary to process my insurance claim for services provided by Morgan County Ambulance Service now and in the future. I further authorize direct payment of any insurance benefits to Morgan County Ambulance Service and its billing company. I also agree to all terms as stated in the MCAS Emergency Transport Business Membership Policy.

Thank you for your membership and for supporting Morgan County Ambulance Service