Life FORCE

THE LEADING FORCE IN PRE-HOSPITAL CARE

Life Force of Western PA Inc.
35 6th Ave.
Greenville, PA 16125
(724) 589-0665

VISA MasterCard DISCOVER NETWORK AMERICAN EXPRESS

Life Force Ambulance Service Membership Plans

Family Plan: ***$40.00 per year***
Coverage for all family members currently residing in a single residence.

Individual Plan: ***$25.00 per year***
Coverage for an individual living alone in a single residence.

Small Business Plan: ***$60.00 per year***
Coverage for all employees, customers and visitors to your business location during hours of operations. Additional plans are available for larger companies with more than 15 employees. Call for details and pricing

Nursing Home Plan: ***$20.00 per year***
Coverage for any individual residing within an Extended Care Facility, Skilled Nursing Home or Personal Care Home.

Name: _____ Dependents: _____
(Name) *(Relationship)*

Address: _____ Apt. # _____

_____

City: _____ State: _____ Zip: _____ Phone: ( ) _____

Other: ( ) _____

Medical Insurance Information: (Check One)

[ ] Medicare [ ] Medical Assistance [ ] High Mark [ ] UPMC [ ] No Insurance [ ] Other: _____

Identification # _____ Group # _____

Medical Authorization / Assignment of Benefits

I request that payment of authorized Medicare, Medicaid or any other insurance benefits be made on my behalf to *Life Force of Western PA Inc.* for any services provided to me by *Life Force of Western PA Inc.* now or in the future. I understand that I am financially responsible for the services provided to me by *Life Force of Western PA Inc. 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 *Life Force of Western PA Inc.* 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 payment to *Life Force of Western PA Inc.* I authorize *Life Force of Western PA Inc.* to appeal 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 *Life Force of Western PA Inc.* and it's billing agents and/or the Centers for Medicare and Medicaid Services and it's carriers and agents and/or any other payers or insurers as may be necessary to determine these or other benefits payable for services provided by *Life Force of Western PA Inc.* now or in the future. A copy of this form is as valid as the original.

Signature: _____ Date: _____

Spousal Signature: _____ Date: _____

Fill application out completely and remit with payment to *Life Force of Western PA Inc.* 35 6th Ave. Greenville, PA 16125