PRIORITY™
AMBULANCE

PRIORITY AMBULANCE SUBSCRIPTION PROGRAM

Take the financial stress out of calling an ambulance.

Priority Ambulance understands that medical transportation can be an unexpected, costly expense. To financially safeguard your family against unforeseen medical emergencies, we offer an affordable annual subscription plan.

Priority Ambulance's subscription program covers the out-of-pocket costs of any medically necessary transport. Our subscription program is not health insurance and does not replace your primary insurance. In the event of a medical emergency, a subscriber's primary insurance would be billed. Any additional balances, deductibles or co-pays not covered by the insurance for services deemed medically necessary by a physician would be covered through Priority Ambulance's subscription agreement.

Join the Priority Ambulance care network, and let us help you protect your family's physical and financial health in an emergency.

NAME: _____

ADDRESS: _____ APT. NO.: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE (____) _____-_____

AMOUNT OF PAYMENT: $ _____(2017 rate is $65)

METHOD OF PAYMENT:

☐ CASH ☐ CREDIT CARD (To make a credit card payment, please call 844-597-4911)

☐ PERSONAL CHECK ☐ MONEY ORDER (PLEASE DO NOT SEND CASH BY MAIL. MAKE CHECKS PAYABLE TO PRIORITY AMBULANCE)

PLEASE COMPLETE FOR EACH MEMBER OF THE HOUSEHOLD. (Each person 18 and older must sign this form for the agreement to be valid.)

CUSTOMER #1: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

CUSTOMER #2: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

CUSTOMER #3: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

CUSTOMER #4: _____ SEX: ☐ F ☐ M

SIGNATURE: _____

PRIMARY INSURANCE: _____

GROUP #: _____

POLICY #: _____

SECONDARY INS: _____

GROUP#: _____

POLICY #: _____

SSN: _____-_____-_____ DOB: _____/_____/_____

RELATION TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

If any member of the household currently has health insurance or Medicare, then this Subscription Agreement must be signed by the health insurance policyholder. If all members of the household are uninsured, then the oldest member of the household must sign this Subscription Agreement. Membership is nontransferable and nonrefundable.

By signing this Subscription Agreement, I hereby acknowledge that I have read, understand and consent to the terms of the agreement outlined on all pages of this form/agreement. I acknowledge having accurately completed the information on this form.

I request that payment of authorized Medicare, Medicaid or any other insurance benefits be made on my behalf to Priority Ambulance, and any affiliates or subsidiaries, for any service provided to me by Priority Ambulance now, in the past, or in the future. I understand that I am financially responsible for the services provided to me by Priority Ambulance, regardless of my insurance coverage, and, in some cases, may be responsible for an amount in addition to that paid by my insurance. I agree to immediately remit to Priority Ambulance 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 payments to Priority Ambulance. I authorize Priority Ambulance 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 Priority Ambulance and its billing agents, and/or the Centers for Medicare & 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 Priority Ambulance, now or in the future. A copy of this form is valid as an original.

Privacy Practices Acknowledgement: I acknowledge that I have received or was offered Priority Ambulance's Notice of Privacy Practices (NPP). I understand that if I would like to receive a copy of the NPP in the future, I may do so by requesting one at info@priorityambulance.com.

PRIORITY AMBULANCE - Subscription Agreement for Ambulance Services

Subscription Fees: I understand that the annual subscription fee is intended to limit my out-of-pocket payments for Medically Necessary Covered Services within the Service Area. Payment of fee may be by cash, check, money order, MasterCard, Visa, Discover or American Express.

Effective Dates: This Subscription will become effective thirty (30) days after a completed Subscription Agreement and full payment are received by Priority Ambulance. This contract will be in effect for a period of one (1) year from that date.

Number of Transports Covered: This agreement covers up to twenty (20) per year. For transports over 20, I understand that I will be responsible for any co-pay or deductibles.

Covered Services: Medical necessity is determined by current Medicare guidelines as published in the "Medicare & You" handbook. Those services include emergency and nonemergency ambulance transportation where transportation by any other means is contraindicated (transportation by any other means would not be safe). Priority Ambulance agrees to accept payment from any primary insurance or third-party payor for medically necessary covered services.

I understand that I am responsible for services that are not medically necessary or that are non-covered services by my insurance carrier (for example, transportation from home to a doctor's office) and that I am to pay those charges at the current Medicare Fee Schedule Rates. Any services provided outside of Priority Ambulance's service area may incur additional cost.

Service Area: For the purposes of this Subscription Agreement the Service Area includes Knox, Blount and Loudon counties in Tennessee.

Eligible Persons: This Subscription Agreement covers all persons residing in subscriber's household. A "household" is defined as subscriber and spouses or single-parent subscriber and their unmarried children under the age of 26 living at the same address. Persons can be added to this Subscription Agreement at an additional cost. Please contact our billing office at 844-597-4911 with any questions regarding extra residents being added to the subscription.

Insurance Billing: I understand that this Subscription Agreement is not insurance and that Priority Ambulance will bill my health insurance provider and will receive payment from this provider for services rendered. I hereby authorize Priority Ambulance to collect such payments and further authorize that payments for insurance claims be made directly to Priority Ambulance. If my health insurance provider sends any payments to me directly for services rendered by Priority Ambulance, I agree to forward such payments immediately to Priority Ambulance.

Release of Information: I hereby authorize the release of any and all medical information necessary to process a claim for services provided as part of this Subscription Agreement to Priority Ambulance.

TennCare/Medicaid: TennCare/Medicaid beneficiaries are not eligible to participate in this program. By signing this Agreement, I certify that neither I nor anyone in my household receives TennCare/Medicaid benefits.

Outside Services: This Subscription Agreement only covers services provided by Priority Ambulance. Services provided by other ambulance companies will not be covered.

Provision of Information: I agree to notify Priority Ambulance within thirty (30) days of any changes in the information I have provided in the attached Subscription Agreement during the term of this contract.

Consumer/Member Right to Cancel: I understand that I may cancel this agreement for a full refund of its Membership Fee any time prior to midnight of the third business day after the date that the agreement was signed. There are no refunds after the third business day.

I agree that Priority Ambulance has reserved the right to void this membership and refund my membership fee from the effective date hereof in the event of my failure to comply with any of these terms. I agree and understand that if my membership is voided, I will be obligated to pay all balances in full. I also understand and agree that failure to comply with membership terms (and grounds for membership revocation) shall include a refusal of any insurer or health care provider to recognize and pay for the services rendered by Priority Ambulance to me or the immediate members of my family, pursuant to the agreement of benefits outlined by this membership agreement.

Signature: _____ Date: _____

MAIL COMPLETED FORM TO:

PRIORITY AMBULANCE

Subscription Agreement for Ambulance Services

910 Callahan Drive, Suite 101 • Knoxville, TN 37912

www.priorityambulance.com • 865-688-4999