PATTON AREA AMBULANCE

2008-2009

ANNUAL SUBSCRIPTION REQUEST
2008-2009

HOUSEHOLD $30.00		DONATION ADDITIONAL $	TOTAL $

PLEASE COMPLETE THE INFORMATION ON BACK SIDE OF THIS FORM.

PLEASE REFER TO YOUR SUBSCRIBER NUMBER ON ALL CORRESPONDENCE.

TEAR ALONG THIS EDGE

PLEASE CORRECT NAME AND ADDRESS

2008-2009 SUBSCRIPTION REQUEST

MAKE CHECK PAYABLE TO:
PATTON AREA AMBULANCE
P.O. BOX 203
PATTON PA 16668

INFORMATION CALLS ONLY:
814-674-3730

ALL EMERGENCY CALLS:
DIAL 9-1-1

SUBSCRIBER NAME:

SUBSCRIBER NO.:

EXPIRES JULY 1, 2009

Amount Paid | Date Paid

Check Number

AUTHORIZATION

I authorize that payment of authorized Medicare Benefits or other insurance benefits be made on my behalf for any services furnished by this health service provider or supplier. I authorize any holder of medical information or documentation about me to release to the Health Care Financing Administration and its carrier and agents, as well as this health service provider, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by this health service provider now or in the future. I understand that I am financially responsible for the services provided to me or my family members by this health service provider or supplier regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the health service provider or supplier or its billing agent for any services provided to me by the health provider or supplier. I authorize and direct any holder of medical information or documentation about me to release to the Center for Medicare and Medicaid Services and its carriers and agents, as well as to this health provider or supplier and their billing agents, any information or documentation needed to determine these benefits payable for any services provided to me by the health service provider, both now or in the future. A copy of this form is as valid as the original. I also agree to immediately remit to this health service provider any payments that I receive directly from any source for the services provided to me, now or in the future.

Signature _____ Date _____

List Family Members To Be Covered

NAME	DATE OF BIRTH	RELATIONSHIP