FIREMED AGREEMENT

(Please read this statement carefully, then sign on the application form.)

The FireMed Ambulance Membership Program is a voluntary service available to residents living within the Clatskanie, Mist-Birkenfeld, Rainier, Scappoose and St. Helens ambulance service areas. I hereby apply for a FireMed Membership for myself, and my dependent *family/household members who live at my address for the FireMed fiscal year. I understand that the membership fee provides **medically necessary pre-hospital care and ambulance transportation within the FireMed Reciprocal Areas.

I understand that medical transportation is based on medical necessity, not on membership status and that patients will be transported to the closest medically appropriate facility.

I understand that my membership covers only ambulance transports in our reciprocal area, which are medically necessary and does not cover the wheel chair car.

I understand that FireMed is not insurance, but will provide service through the FireMed Reciprocal agencies. FireMed will bill whatever insurance or medical benefits I may have and is entitled to primary and secondary insurance payment. FireMed is in excess of any insurance or medical benefits, which I may have.

I transfer, directly to the provider of service, my rights to insurance payment from my primary and secondary insurance carrier as payment in full. Such payment shall not exceed regular charges. Should a family member or I receive payment from insurance or other medical benefits provider for ambulance service rendered by a FireMed Reciprocal Agency, I will immediately forward such payment to the provider of service.

I further authorize the release of medical information for the purpose of ambulance insurance billing only.

FireMed membership is not solicited from persons who receive welfare medical benefits and such membership constitutes a voluntary contribution only.

I understand that violations of the terms of this agreement may result in immediate cancellation. This membership is non-refundable, non-transferable and not pro-rated.

I also understand that my $50.00 fee is not tax-deductible.

New member benefits take effect after receipt of completed application and payment, plus 24 hours.

*Definition of Family

FireMed membership covers immediate family members living in the same household. The member, spouse, unmarried children under age 25 and other persons listed as legal dependents for income tax purposes are covered. Others not included in this definition are required to obtain their own separate membership.

**Definition of Medically Necessary

Medical necessity is satisfied when the “Lack of Transport” could place the patient’s health in serious jeopardy; could cause impairment of bodily functions; or another mode of transportation could endanger the health of the patient.

Member Benefits in Other Areas

Member benefits are extended to areas outside of the Local FireMed service area within the state of Oregon. FireMed benefits outside of Oregon are covered with agencies belonging to the National Association of Reciprocating E.M.S. These benefits are limited to the terms of agreement in effect by each individual FireMed participating agency at the time benefits are used. Members who receive ambulance service from any other FireMed participating agency are eligible for benefits offered by that agency.

Call or visit the administrative office of your local Fire District.
Scappoose RFPD, 503-543-5026; Mist/Birkenfeld RFPD, 503-755-2710;
Clatskanie RFPD, 503-728-2025; Columbia River Fire & Rescue, 503-397-2990

FireMed Membership Application

Service of Columbia River Fire & Rescue,
Clatskanie, Scappoose &
Mist/Birkenfeld Fire Districts
P.O. Box 911
St. Helens, OR 97051

You may choose to join Life Flight for an additional $45.00.

(Please Print)

Primary Member

Birth Date: Month _____ Day _____ Year _____ Female _____ Male _____ Jr. _____ Sr. _____

Last Name: ____________________ First Name: ____________________ Middle Initial: ________

Street Address: ____Apt.# ________________

City: ____________________ State: ____________ Zip: ________________

Telephone, Home: ____________________ Telephone, Business: ____________________

Mailing Address *(if different than above)*: ____

City: ____________________ State: ____________ Zip: ________________

Other Household Members

	Last Name	First Name	MI	Date of Birth
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Please read the Lower Columbia FireMed agreement on the reverse side.

Join Now! Please complete this form, sign on the signature line below (all appropriate household members), and return along with your payment. This form **must be signed** by all persons in the household covered by this membership who are 18 years of age and older.

Primary Member

(Signature) ________________________________

Household Members (Signatures)

1. ________________________________

2. ________________________________

3. ________________________________

4. ________________________________

Your $50.00 payment must accompany this application. Please make your check payable to *Lower Columbia FireMed*.

O FireMed only $50.00 O Life Flight only $65.00
O Both FireMed and Life Flight $95.00 per year
O Tax-deductible donation

Office Use Only:

Date Received ____________ Cash ____________
Check # ____________ Receipt #____________
Card Sent ______ Life Flight Sent ____________
Notes: ________________________________