KANSAS CITY, KANSAS FIRE
DEPARTMENT

Emergency Medical Services Division

Office: 913-573-5550
Fax: 913-342-9610

Ambulance Membership Program

Please fill out the application completely, sign the application, and return the form along with the required fee, or your application will be returned to you and your membership declined.

Membership in the Ambulance Membership Program permits the Kansas City, Kansas Fire Department (KCKFD) to collect directly from any third-party agency (Medicare, private insurance, etc.) any and all benefits that may be available to the member. For services covered by the Ambulance Program, KCKFD will accept any available third-party benefits and will write off any unpaid balances unless a third-party agency refuses to pay such benefits because of membership in the Ambulance Program. The Ambulance Program is not insurance, and members are legally responsible to pay for KCKFD services.

Individual and family memberships are available. An individual membership covers only the applicant. A family membership includes the applicant plus his or her spouse or domestic partner and dependent relatives living in the same residence or in a nursing home in Kansas City, Kansas. Dependent relatives may include parents, children, grandchildren, great-grandchildren, or siblings of the applicant or the applicant's spouse or domestic partner. The applicant's spouse or domestic partner and dependent relatives must be listed on the application to be eligible for membership. If at any time the applicant's membership lapses or is terminated, the memberships of the applicant's spouse or domestic partner and dependent relatives will no longer be valid.

Membership covers medically necessary emergency ambulance transportation provided by KCKFD (when available) from Kansas City, Kansas to the closest appropriate hospital. Membership also covers medically necessary non-emergency ambulance transportation provided by KCKFD (when available) from Kansas City, Kansas to a point not more than 30 miles from the point of origin. Membership does not cover non-emergency ambulance transportation for patients who can walk or sit in a wheelchair. A physician certification statement (PCS) documenting the medical necessity for transport is required for all non-emergency transports.

Membership does not guarantee or create a legal right to ambulance transportation. The membership fee is non-refundable, and the membership is non-transferable. Membership will be terminated if the Unified Government determines that a member has abused his or her privileges by unnecessarily utilizing KCKFD services. This is not a solicitation for Medicaid recipients.

Ambulance Membership Program

Please check one:

☐ This is an application for a new membership

☐ This is a renewal application. My membership number is: _____

Please fill out this form completely, sign the form on the opposite side and return this form along with the fee or your application will be returned to you and your membership declined.

PRIMARY MEMBER

Last Name		Telephone
Street Address		Apt Number
City	State	ZIP
Mailing Address (if different than above)		
City	State	ZIP

For Family Memberships, list all family members, including dependents on the next page. Please list any last name that is different than the name above.

List of Family Members

	Last Name	First Name	M.I.	Relationship to Primary Member	Date of Birth	
Primary Member				**Self**		
Spouse/Partner				**Spouse/Partner**		
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						

Membership Plans (select one)

☐ $40 Individual, 1 year ☐ $55 Family, 1 year

☐ $70 Individual, 2 years ☐ $100 Family, 2 years

For Office	Use Only
Treasurer's Office Only	Fire Dept./EMS Only
Date Rec'd:_____	Date Entered_____
Amt. Rec'd:_____	Exp. Date_____
Recpt. #_____	Entered By:_____

BILLING AUTHORIZATION AND RESPONSIBILITY FOR PAYMENT

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

Applicant or other Authorized Person:

Signature: _____ Date: _____

Print Name: _____

MEMBERSHIP SIGNUP PERIOD IS JULY – OCTOBER OF EACH YEAR

A check or money order must accompany this application. Please make checks payable to "Unified Treasurer". Please do not send cash.

COMPLETE PAGES 2 & 3, AND RETURN WITH YOUR PAYMENT TO:

KCKFD Ambulance Membership Program
c/o Unified Government Treasurer
710 North 7th Street
Kansas City, KS 66101