



KANSAS CITY, KANSAS FIRE  
DEPARTMENT

Emergency Medical Services Division



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

**Ambulance Membership Program**

**Please complete the application in full, sign it, and return the form along with the required fee. If you do not, your application will be returned to you, and your membership will be 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 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; members are legally responsible for paying for KCKFD services. If insurance deems the transport as "non-medically necessary," you will be billed the full amount.

Individual and family memberships are available. An individual membership covers only the applicant. A family membership includes the applicant, their 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. We no longer provide non-emergent transports. Recent changes to dispatch will now send the closest ambulance available for 911 calls. This does not guarantee that KCKFD ambulances will transport you. If another service (such as Bonner Springs or Edwardsville) transports you or a family member, this membership will not cover those costs.

Membership does not guarantee or create a legal right to ambulance transportation or a different level of care. 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						

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 I have received. 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 7<sup>th</sup> Street  
Kansas City, KS 66101**