BARTLESVILLE AMBULANCE

MEMBERSHIP APPLICATION

Please print or type.
THIS IS NOT AN APPLICATION FOR AN INSURANCE POLICY.

FOR OFFICE USE ONLY

DATE RECEIVED	PAYMENT FORM	AMOUNT

Applicant	2nd Adult
LAST NAME	LAST NAME
FIRST NAME	FIRST NAME
DATE OF BIRTH	DATE OF BIRTH
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
MEDICARE NUMBER	MEDICARE NUMBER

APPLICANT'S MAILING ADDRESS - STREET		EMAIL:	
CITY	STATE	ZIP CODE	AREA PHONE NUMBER ( )

FULL NAME AND DATE OF BIRTH OF EACH QUALIFIED CHILD (SEE MEMBERSHIP AGREEMENT) UNDER THE AGE OF 21 LIVING IN YOUR HOUSEHOLD INDICATING THEIR RELATIONSHIPS (S = SON, D = DAUGHTER)

If added space is needed, please attach a list

Name	Date of Birth	Relationship

Applicant	Spouse
OTHER INSURANCE COMPANY	OTHER INSURANCE COMPANY
IDENTIFICATION NUMBER	IDENTIFICATION NUMBER
GROUP	GROUP
ADDRESS TO SEND INSURANCE CLAIM	ADDRESS TO SEND INSURANCE CLAIM
☐ IS FAMILY COVERED ☐ IS SPOUSE COVERED	☐ IS FAMILY COVERED ☐ IS SPOUSE COVERED

I authorize any holder of medical information or documentation about me or any person covered under my Primary Care membership to release to Bartlesville Ambulance and the Health Care Financing Administration and its agents and carriers any information or documentation needed to determine benefits payable for services provided to a covered person by Bartlesville Ambulance now or in the future. I hereby assign to Bartlesville Ambulance all my rights and benefits for ambulance services provided by any and all of my insurers and any third party agencies. I further authorize my insurers and any third party agencies to pay directly to Bartlesville Ambulance whatever benefits or payments may be available for services rendered to me or my dependents by Bartlesville Ambulance. I have read the BAS Primary Care Agreement and agree to the terms.

I agree to provide Bartlesville Ambulance all information necessary to file a claim for payment under my insurance policy, plan or program or from any third payor.

Membership contract must be signed by the insurance policy holder. Membership is non-transferable and non-refundable and may be canceled upon member's non-compliance herewith.	SIGNATURE	DATE

PLEASE SIGN THE PRIMARY CARE AGREEMENT AND SEND THE AGREEMENT AND PAYMENT TO:

Bartlesville Ambulance
P.O. Box 1051
Bartlesville, OK 74005
(918) 336-1111