

Care Flight - Flight Plan Application

Please print or type all information, sign, and return with your payment.

head of household			<input type="checkbox"/> new	<input type="checkbox"/> renewing
Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Mailing Address				
City, State, Zip Code				
Home Phone #	Date of Birth			
Social Security #	Medicare #			
Insurance Company Name				
Insurance Company Address				
Insurance Company Phone #				
Policy or I.D. #	Group #			
Insurance Carried through (Employer, Union)			Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insured Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____				

spouse			<input type="checkbox"/> other	<input type="checkbox"/> new	<input type="checkbox"/> renewing
Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F			
Date of Birth					
Social Security #					
Medicare #					
Insurance Company Name					
Insurance Company Address					
Insurance Company Phone #					
Policy or I.D. #	Group #				
Insurance Carried through (Employer, Union)			Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Insured Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____					

Add separate sheet for other household members if necessary.

child			<input type="checkbox"/> dependent	<input type="checkbox"/> other
Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Date of Birth	Social Security #	Medicare #		
Insurance Company Name			Insurance Company Phone #	
Insurance Company Address				
Policy or I.D.#	Group#			
Insurance Carried through (Employer, Union, etc)			Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insured Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other _____				

child			<input type="checkbox"/> dependent	<input type="checkbox"/> other
Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Date of Birth	Social Security #	Medicare #		
Insurance Company Name			Insurance Company Phone #	
Insurance Company Address				
Policy or I.D.#	Group#			
Insurance Carried through (Employer, Union, etc)			Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insured Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other _____				

child			<input type="checkbox"/> dependent	<input type="checkbox"/> other
Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Date of Birth	Social Security #	Medicare #		
Insurance Company Name			Insurance Company Phone #	
Insurance Company Address				
Policy or I.D.#	Group#			
Insurance Carried through (Employer, Union, etc)			Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insured Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other _____				
Referred by: _____				

child			<input type="checkbox"/> dependent	<input type="checkbox"/> other
Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Date of Birth	Social Security #	Medicare #		
Insurance Company Name			Insurance Company Phone #	
Insurance Company Address				
Policy or I.D.#	Group#			
Insurance Carried through (Employer, Union, etc)			Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insured Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other _____				

public safety affiliation
Do you work in Public Safety? If yes, please list agency name:

group affiliation
Group name:

application instructions

1. Each applicant must fill out all information.
2. Each applicant age 18 and over must sign each application.
3. Include payment in envelope with your completed signed application.
4. Please print the application, sign and mail the entire application form.
5. If there are not enough spaces for all members of your household, please use another piece of paper and add the applicant's complete information.

method of payment Please select one

\$55 per Household or Approved Group Rate of \$ _____

Check Money Order (payable to Care Flight)

Credit/Debit Card VISA MasterCard

Debit or Credit Card # _____ Expiration Date _____

Cardholder's signature _____

IMPORTANT ! By signing below, I acknowledge that I have read the Flight Plan membership agreement. I understand and agree to the terms of the entire agreement. I hereby certify that the information contained herein is true and accurate

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Flight Plan Membership Agreement

This is not an application for an insurance policy.

- I understand that my Flight Plan membership fee covers my portion of Care Flight's services that are applied to co-insurance or deductibles by insurance or Medicare for medically necessary transports. "Medically necessary" is defined as specific need of air ambulance transportation to the nearest medically appropriate hospital as requested by a physician or as directed by state/county protocols.
- I understand that Flight Plan is not an insurance policy nor is it meant to be a substitute for health insurance. I agree that if I have no insurance or other health coverage, or if my insurance company or other health benefits payer denies payment to Care Flight because it determines that my air ambulance services were not medically necessary, I will be responsible for the payment of the fees for those services, less a 20% discount because I am a Flight Plan member.
- I understand that my Flight Plan membership covers those persons who are permanently residing in my household and who are listed on my application. A "household" is defined as all persons who permanently reside at the "Head of Household's" physical address listed on the Membership Application or in a nursing home.
- I understand that Flight Plan benefits only apply when a Flight Plan member is transported by Care Flight or a reciprocating program (see list of programs).
- I understand that Flight Plan membership does NOT cover the services of REMSA or SEMSA's ground ambulance service.
- I understand that the Flight Plan membership program may be cancelled at any time for any reason.
- I understand that my membership is non-transferable and non-refundable.
- I understand that Medicaid/Med-Cal recipients are not eligible for Flight Plan membership due to their own policies, and I verify that I am not a Medicaid/Medi-Cal recipient.

- I understand that the effective date for my membership is the date that Care Flight receives my completed and signed Membership Application and fee, and is effective for one year.

- **ASSIGNMENT OF BENEFITS:**

I understand that my Flight Plan membership is not an insurance plan and that Care Flight will bill and receive payments from my insurer or third party (such as Medicare, Blue Cross, etc.). I hereby authorize all benefits be paid directly to Care Flight. If I have Medicare, I request that payment or authorized Medicare benefits be made on my behalf to Care Flight for any air ambulance service provided to me by Care Flight. If I receive payment from Medicare or my insurance company, I will immediately forward that payment to Care Flight. If I do not, I understand that my membership may be terminated and I will be billed full charges for Care Flight services. I acknowledge that I am responsible for payment of air ambulance services.

- **LIFETIME SIGNATURE AUTHORIZATION:**

To facilitate processing, I authorize the release to the Centers for Medicare and Medicaid Services or other insurer of any medical information or documentation held by anyone necessary to process a claim now or in the future, and further assign and authorize such payments to Care Flight. I permit a copy of this authorization to be used in place of the original. If I receive payment from Medicare or may insurance company, I will immediately forward that payment to Care Flight. If I do not, I understand that my membership may be terminated and I will be billed in full for all services rendered.

- The Flight Plan Membership Program is not insurance. You will not be covered if transported by an air ambulance company other than Care Flight or a AAMMP reciprocating program. See the web site <http://care-flight.com/flightplan.html> for a current list. Air ambulances sent in an emergency are determined by the 911 Emergency System. The closest aircraft will be sent. This may also occur if Care Flight is unable to respond within a medically appropriate period due to all aircraft being on other calls, weather, or maintenance issues. Reciprocity between AAMMP member programs is subject to the reciprocating program's rules.

Every person over the age of 18 must sign this application form. Then mail to Care Flight with your membership fee in the postage-paid envelope provided. Care Flight is a division of REMSA, and aviation services are provided by Air Methods Corporation, QMLA253U. Care Flight is compliant with HIPAA regulations. A copy of our Notice of Privacy Practices is available on request, or visit our website at www.remsa-cf.com

Care Flight • 450 Edison Way • Reno, NV 89502

Phone 775.858.5700 • fax 775.858.5731