# ARIZONA FIRE & MEDICAL AUTHORITY

*18818 N. Spanish Garden Drive, Sun City West, AZ 85375 • P (623) 544-5400 • F (623) 544-5455 • www.afma.az.gov/amp*

## AMBULANCE MEMBERSHIP PROGRAM AGREEMENT

**Primary Contact Information**

**Name:** ________________________________ **Date of Birth:** _____-_____-_______
*Your name must match your primary insurance card exactly* **MM DD YYYY**

**Sex:** ☐ **Male** ☐ **Female** **Social Security Number:**_______-______-________

**Telephone #:** _______-_______-________ **Email Address:**_____________________________

**Home Address (*must be within an AFMA Ambulance Service Area*)**

Facility Name (optional):_________________________________________________
Street Address:_______________________________________________________
Mailing Address *(If different from above)*:_____________________________________
City:_____________________________State:_____________Zip Code:______________

☐ **Copies of insurance card(s) front and back attached. If attached, skip this section.**

**Primary Insurance Carrier Name:**_________________________________________
Policy/Subscriber/Insured #:____________________________Group #:_______________
Claim Mailing Address:__________________________________________________
City:_____________________________State:_____________Zip Code:______________

**Secondary Insurance Carrier Name:**_______________________________________
Policy/Subscriber/Insured #:____________________________Group #:_______________
Claim Mailing Address:__________________________________________________
City:_____________________________State:_____________Zip Code:______________

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**Dependent Contact Information** ***(Relationship to Primary Contact:*___________________________*)***

**Name:** ________________________________ **Date of Birth:** _____-_____-_______
*Your name must match your primary insurance card exactly* **MM DD YYYY**

**Sex:** ☐ **Male** ☐ **Female** **Social Security Number:**_______-______-________

☐ **Copies of insurance card(s) front and back attached. If attached, skip this section.**

**Primary Insurance Carrier Name:**_________________________________________
Policy/Subscriber/Insured #:____________________________Group #:_______________
Claim Mailing Address:__________________________________________________
City:_____________________________State:_____________Zip Code:______________

**Secondary Insurance Carrier Name:**_______________________________________
Policy/Subscriber/Insured #:____________________________Group #:_______________
Claim Mailing Address:__________________________________________________
City:_____________________________State:_____________Zip Code:______________

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**Revised: 06/14/2024**

The Arizona Fire & Medical Authority (AFMA) Ambulance Membership Program (AMP) is offered to Authority residents as an alternative to paying out of pocket costs for AFMA provided medically necessary ambulance transport service. With an ambulance membership, your insurance company will be billed after you utilize our transport service. The membership fee alleviates the member's liability for cost-sharing amounts. If your medical insurance does not require you to pay a co-pay and/or deductible for ambulance transportation, this program would **not** be beneficial to you. Residents are strongly encouraged to check with your medical insurance company to verify if a co-pay and/or deductible is required. **The membership program is not an insurance policy.**

This agreement provides membership in the ambulance subscription program known as the AFMA Ambulance Membership Program. The annual membership fee per household alleviates the member's liability for cost-sharing amounts for medically necessary ground ambulance service within the approved AFMA service area, to the nearest appropriate medical facility, for the subscriber and household members for one year, including physician-authorized, medically necessary ambulance service from a point within the AFMA approved area to a hospital within the State of Arizona. T**he annual fee for this program is $88.53 per household**.

If any member of the household currently has health insurance or Medicare, then this subscription agreement must be signed by the health insurance policyholder. Membership is nontransferable and nonrefundable.

By submitting this subscription agreement, I hereby acknowledge that I have read, understand, and consent to the terms of the agreement outlined on all pages of this form/agreement. I acknowledge having accurately completed the information on this form.

**Privacy Practices Acknowledgement:** I acknowledge that I have received or was offered Arizona Fire & Medical Authority's Notice of Privacy Practices (NPP). I understand that if I would like to receive a copy of the NPP in the future, I may do so by requesting one at info@afma.az.gov.

**Subscription Fees:** I understand that the annual subscription fee is intended to alleviate the member's liability for cost-sharing amounts for medically necessary covered services within the service area. Payment of fee may be by check, money order, debit or credit card.

**Effective Dates:** The effective date of this agreement shall be the date your completed subscription agreement and fee are received and approved by the Authority. This agreement will be in effect for a period of one (1) year from that date.

**Covered Services:** Medical necessity is determined by current Medicare guidelines as published in the "Medicare & You" handbook. Those services include emergency and nonemergency ambulance transportation where transportation by any other means is contraindicated (transportation by any other means would not be safe). Arizona Fire & Medical Authority agrees to accept payment from any primary insurance or third-party payer for medically necessary covered services.

I understand that I am responsible for services that are not medically necessary or that are non-covered services by my insurance carrier (for example, transportation from home to a doctor's office) and that I am to pay those charges. Any services provided outside of Arizona Fire & Medical Authority's service area may incur additional cost.

**Service Area:** The Arizona Fire & Medical Authority's Ambulance Membership Program services the residents of the North County Fire & Medical District which includes the unincorporated community of Wittmann and the residents of the South County Fire & Medical District, excluding the unincorporated community of Tonopah and the Ironwood Estates subdivision in the unincorporated community of Sun Lakes. The unincorporated communities of Buckeye Valley Fire District are also excluded.

**Eligible Persons:** This subscription agreement covers all permanent residents living in the household when included on the subscription/membership plan application or are added later during the membership term. Additional permanent household members can be added during the membership term when a written addendum is received. Please contact our billing office at 800-953-9777 with any questions regarding the addition of permanent household members to the subscription.

**Insurance Billing:** I understand that this subscription agreement is not insurance, and that Arizona Fire & Medical Authority will bill my health insurance plan/third-party liability and will receive payment from this source for services rendered If my health insurance plan/third-party liability sends any payments to me directly for services rendered by Arizona Fire & Medical Authority, I agree to forward such payments immediately to Arizona Fire & Medical Authority.

**AHCCCS/Medicaid:** AHCCCS/Medicaid beneficiaries are not eligible to participate in this program. By signing this agreement, I certify that neither I nor anyone in my household receives AHCCCS/Medicaid benefits.

**Outside Services:** This subscription agreement only applies to services provided by Arizona Fire & Medical Authority. Services provided by other ambulance companies will not be considered.

**Provision of Information:** I agree to notify Arizona Fire & Medical Authority within thirty (30) days of any changes in the information I have provided in the attached subscription agreement during the term of this contract.

**Consumer/Member Right to Cancel:** I understand that I may cancel this agreement for a full membership fee refund any time prior to midnight of the third business day after the date that the agreement was signed. There are no refunds after the third business day.

I agree that Arizona Fire & Medical Authority has reserved the right to void this membership and refund my membership fee from the effective date hereof in the event of my failure to comply with any of these terms. I agree and understand that if my membership is voided, I will be obligated to pay all balances in full. I also understand and agree that failure to comply with membership terms (and grounds for membership revocation) shall include a refusal of any insurer or health care provider to recognize and pay for the services rendered by Arizona Fire & Medical Authority to me or the immediate members of my family, pursuant to the agreement of benefits outlined by this membership agreement.

This is not an application for an insurance policy or supplemental. Please read and sign this Ambulance Membership Program Agreement. Completed agreements must be mailed or delivered to the AFMA Administrative Office located at 18818 N. Spanish Garden Drive, Sun City West, AZ. 85375 or delivered to AFMA Fire Station 232 located at 25020 S. Alma School Road, Sun Lakes, AZ. 85248 during regular business hours.

I request that payment of authorized Medicare, Medicaid or any other insurance benefits be made on my behalf to Arizona Fire & Medical Authority, and any affiliates or subsidiaries, for any service provided to me by Arizona Fire & Medical Authority now, in the past or in the future. I understand that I am financially responsible for the services provided to me by Arizona Fire & Medical Authority, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that paid by my insurance. I agree to immediately remit to Arizona Fire & Medical Authority any payments that I receive directly from insurance or any source whatsoever for the services provided to me, and I assign all rights to such payments to Arizona Fire & Medical Authority. I authorize Arizona Fire & Medical Authority to appeal payment denials or other adverse decisions on my behalf without further authorization.

I authorize and direct any holder of medical information or documentation about me to release such information to Arizona Fire & Medical Authority and its billing agents, and/or the Centers for Medicare & Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by Arizona Fire & Medical Authority, now or in the future. A copy of this form is valid as an original.

Primary Signature (required): ____________________________________________ Date:_______________________

Secondary Signature (required): ____________________________________________ Date:_______________________

## AMBULANCE MEMBERSHIP PROGRAM PAYMENT INFORMATION

**The annual cost for an Ambulance Membership is $88.53.**

**Please complete the payment information below:**

☐ Check/Money Order (Annual renewal notices will be mailed.)

☐ Credit/Debit Card

Card #______________________________________________3-digit Security Code: ________ Expiration Date:____________

Cardholder Name:___________________________________Signature:______________________________________

Include this completed application (pages 1-3) and check or credit/debit card information. Mail to:

Arizona Fire & Medical Authority
18818 N. Spanish Garden Dr.
Sun City West, AZ 85375

Membership will be effective when your completed subscription agreement and fee are received and approved by the Authority. Your membership is maintained electronically. We do not send Membership Cards. **Membership Questions? 1-800-953-9777**

Please retain the following Notice of Privacy Practices for your records:

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Notice of Privacy Practices

**ARIZONA FIRE & MEDICAL AUTHORITY**

*(North County Fire & Medical District and South County Fire & Medical District)*

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

This Notice of Privacy Practices ("Notice") describes the legal duties of the Arizona Fire & Medical Authority ("Provider," "we," "us," or "our") and your legal rights regarding your protected health information ("PHI") in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

**Provider Responsibilities.** The Provider is required by law to:

- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect.

**Uses and Disclosures of PHI.** The Provider may use or disclose PHI for the purposes of treatment, payment, and health care operations without your written permission, in most cases. Examples of our use or disclosure of your PHI include the following:

*For Treatment*. This includes such things as obtaining verbal and written information about your medical condition and treatment from you, as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment and may transfer your PHI via radio or telephone to the hospital or dispatch center.

*For Payment*. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations, and collecting outstanding accounts.

*For Health Care Operations*. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

*Reminders for Scheduled Transports and Information on Other Services*. We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or to provide information about other services we provide.

*Use and Disclosure of PHI Without Your Authorization*. The Provider is permitted to use or disclose PHI without your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment, or health care operations activities of another health care provider who treats you;
- For health care and legal compliance activities;
- To business associates that perform various functions on our behalf or to provide certain types of services which includes billing for ambulance or other Emergency Medical Services and administration of the Authority's Ambulance Membership Program;
- To a family member, other relative, close personal friend, or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
- To a public health authority in certain situations, as required by law (such as to report abuse, neglect, or domestic violence);
- For health oversight activities, including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or its contractors) by law to oversee the health care system;
- For judicial and administrative proceedings, as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security, and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or as necessary to carry out their duties, as authorized by law;
- If you are an organ donor, to an organization that handles organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals; and
- In a manner that does not personally identify you or reveal who you are.

*Use and Disclosure of PHI With Your Authorization*. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time,

so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any PHI that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

**Patient Rights**. As a patient, you have a number of rights with respect to your PHI, including:

*The Right to Access, Copy, or Inspect Your PHI*. You have the right to inspect and copy certain types of your PHI. We will generally provide you with access to this PHI within 30 days of your request. If the PHI you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic format you request if the PHI can be readily produced in that format. If the PHI cannot be readily produced in that format, we will work with you to come to an agreement on format. If we cannot agree on an electronic format, we will provide you with a paper copy. To inspect and copy your PHI, please contact our Privacy Officer (as set forth below). If you request a copy of the PHI, we may charge a reasonable fee for you to copy any PHI that you have the right to access. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your PHI, we will provide a written denial, and you may request that the denial be reviewed by submitting a written request to our Privacy Officer.

*The Right to Receive Confidential Communications*. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, please contact our Privacy Officer. Your request must specify' how or where you wish to be contacted. We will accommodate all reasonable requests.

*The Right to Amend Your PHI*. You have the right to ask us to amend PHI that we may have about you. We will generally amend your PHI within 60 days of your request and will notify you when we have amended the PHI. We are permitted by law to deny your request to amend your PHI only in certain circumstances, like when we believe the PHI you have asked us to amend is correct. If you wish to request that we amend the PHI that we have about you, please contact our Privacy Officer.

*The Right to Request an Accounting*. You may request an accounting from us of certain disclosures of your PHI that we have made in the six years prior to the date of your request. We are not required to give you an accounting of uses or disclosures for purposes of treatment, payment, or health care operations, or when we share your PHI with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses and disclosures of PHI for which you have given us written authorization. If you wish to request an accounting, please contact our Privacy Officer.

*The Right to Request that We Restrict the Uses and Disclosures of Your PHI*. You have the right to request that we restrict how we use and disclose your PHI. Except as provided below, the Provider is not required to agree to any restrictions you request. However, any restrictions agreed to by the Provider in writing are binding on the Provider. We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment), and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, please contact our Privacy Officer.

*The Right to Be Notified of a Breach*. You have the right to be notified in the event that we (or a business associate) discover a breach of unsecured PHI.

*Other Applicable Laws*. HIPAA generally does not preempt other laws that give individuals greater privacy protections. Therefore, if any state or federal privacy law requires us to provide you with more privacy protections, then we will also follow that law in addition to HIPAA.

*Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request*. If we maintain a website, we will prominently post a copy of this Notice on our web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

*Revisions to the Notice*. The Provider reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our Privacy Officer.

*Your Legal Rights and Complaints*. You also have the right to complain to us or to the Secretary of the United States Department of Health and Human Services ("Secretary") if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or the Secretary. To file a complaint with the Provider, or if you have any questions or comments regarding this Notice, please contact our Privacy Officer. Please note that all complaints filed with the Privacy Officer must be submitted in writing.

Privacy Officer Contact Information:
Dusty Christopherson, Administrative Director (Privacy Officer)
Arizona Fire & Medical Authority
18818 North Spanish Garden Drive
Sun City West, AZ 85375
dchristopherson@afma.az.gov
Phone: 623-544-5400

**Effective Date of this Notice: August 01, 2021**