Community Ambulance Service, Inc.
SUBSCRIPTION FORM

Please Print and mail back to: OR To Pay by Credit Card:

Community Ambulance Service, Inc.
P.O. Box 909
Franklin, PA 16323

Call 437-3016 / press 1

Make Checks Payable to: Community Ambulance Service, Inc.

Check one: ☐ NEW ☐ RENEWAL

Check one: ☐ Indivdual…..$40.00 ☐ Senior Citizen Individual…..$35.00

☐ Household…..$50.00 ☐ Senior Citizen Couple…..$40.00

***Please Print:**

Name:_____ Address:_____ Municipality:_____

City:_____ Zip:_____ Phone Number:_____Cell_____

Subscription Rate:_____

Donation Optional:_____

Total Enclosed:_____

I understand that I am financially responsible for the services provided to me by Community Ambulance Service, Inc ("CAS") regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to CAS for any services provided to me by CAS. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to CAS and its billing agents and my other payers or insurers, any information or documentation needed to determine these benefits or benefits payable for any service provided to me by CAS, nor or in the future. I agree to immediately remit to CAS any payments that I received directly from any source for the services provided to me and I assign all rights to such payments to Community Ambulance Service, Inc.

I hereby apply for the within indicated subscription with Community Ambulance Service, Inc. and agree to be bound by all of the Subscription Terms and Conditions, which are now by reference incorporated herein.

Signature(X)_____
Head of Household

Please List Below the Family Members Residing in Your Home

First Name	Last Name