2024-2025
Ambulance Subscription Drive

Now serving Elizabeth and parts of Clay Townships

Ambulance Services are Not Free! Join Today!

Warwick Community Ambulance Association is pleased to offer you a subscription program. Our annual subscription, runs June 1, 2024 to May 31, 2025, provides peace of mind for you and your loved ones by protecting you from potentially large out-of-pocket expenses. Our subscription offers a convenient, affordable and discounted solution to lessen the risk non-subscribers may face if insurance doesn't cover the bill.

We Need Your Help!

In addition to the ambulances which are now on a scheduled replacement plan, we are turning our building across the alley back into a garage to house our additional vehicles. Any donations would be greatly appreciated! Please consider helping us fund this needed addition so we can continue to provide top notch service.

In the Event of an Emergency

DIAL 911

Non-Emergencies: (717) 626-1200

Detach and return this portion with your payment in the envelope provided.

Warwick Community Ambulance Association

2024-2025 Subscription Request Form

Make check payable to *Warwick Community Ambulance Association*
Please complete all applicable fields; use additional paper if necessary
****Authorization must be signed on the back in order to activate subscription**

Check the Applicable Box Below

☐	Senior Individual	$50.00
☐	Senior Family	$70.00
☐	Individual	$60.00
☐	Household	$80.00

Please make any corrections to name/address below	Family Member Names (First & Last)	Birth Date	Relation

2024-2025 Subscription Overview

Why Should I Become A Subscriber?

Warwick Community Ambulance Association is **NOT funded by tax dollars.** Subscriptions and tax-deductible donations do a large part in making it possible to continue serving you.

Based on the status of your deductibles and copays, **the subscription to WCAA reduces or eliminates the portion of emergency Basic Life Support and Advanced Life Support service that is not paid by insurance or Medicare. (Non-subscribers ARE BILLED for the balance not covered by insurance).**

3rd Party Billing Information

Your insurance company will be billed for any ambulance transportation or service provided. After the insurance settles, any remaining balance is waived for ***subscribers only when*** the following criteria are met:

1) The service is an emergency
2) The transport follows Medicare's definition of medical necessity, and
3) Your deductible has been met

If insurance is applied to your deductible we will reduce your payment to 50% of the total. Medicare and most insurance plans will not cover 100% of the bills incurred for ambulance transportation. Uninsured subscribers need to contact our office for more information.

Some insurance companies will pay the patient directly for our services. When this happens we ask that you immediately endorse the check and forward it to WCAA's billing office at PO Box 726, New Cumberland, PA 17070. Keeping the check will be considered theft of services.

Subscribers also are offered a 25% discount on wheelchair and non-emergent ambulance transports.

Subscription Cards

Subscription cards are not issued to subscribers.

Please retain this document for your records.

2024-2025 Subscription Record
Check #
Date
Amount
Subscription Level
Donation

Subscription Level	Cost
Senior Individual (Age 60+)	$50.00
Senior Family (Ages 60+)	$70.00
Individual	$60.00
Household (2+ individuals)	$80.00

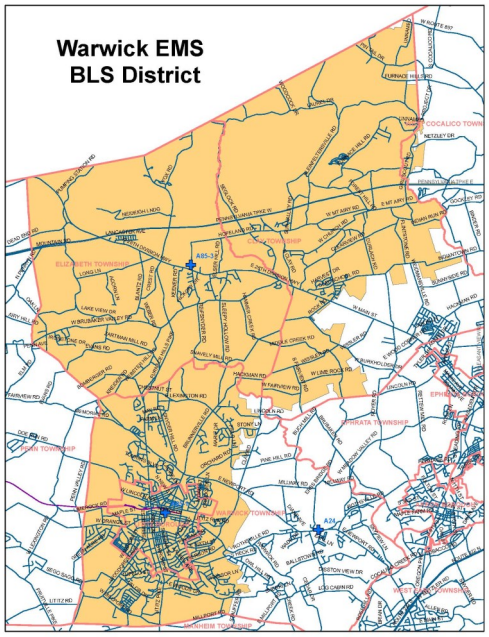
All subscriptions and donations are tax deductible and non-refundable.

Sign Up & Pay Online!

Don't want the hassle of cutting a check and mailing in the application?

Subscriptions can easily be completed online and paid via credit card at:

www.warwick-ems.org



AUTHORIZATION

I authorize that payment of authorized Medicare benefits and/or other insurance benefits be made on my behalf for any services furnished by this health service provider. I authorize any holder of medical information or documentation about me to release to the Health Care Financing Administration and its carrier and agents, as well as this health service provider, any information or documentation needed to determine these benefits or benefits payable for any service provided to me by this health service provider now or in the future. I understand that I am financially responsible for the services provided to me or my family members by this health service provider or supplier regardless of my insurance coverage. I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to the health service provider or supplier or its billing agent for any services provided to me by the health provider. I authorize and direct any holder of medical information or documentation about me to release to the Center for Medicare and Medicaid Services and its carriers and agents, as well as to this health provider and their billing agents, any information or documentation needed to determine these benefits payable for any service provided to me by the health service provider, both now or in the future. A copy of this form is valid as the original. I also agree to immediately remit to this health service provider any payments that I receive directly from any source for the services provided to me, now or in the future.

Signature: _____ **Email**: _____ **Date**: _____