Membership Application

Application Information		❑ RENEWAL		❑ NEW MEMBER
Name	SSN	Date of Birth	Gender	
Physical address				**Source**
City	State	ZIP	Phone #	❑ Radio
Mailing address (if different)				❑ Newspaper
City	State	ZIP		❑ Television

Household Members	SSN	Date of Birth	Gender	Covered by Insurance	❑ Billboard
				❑ Y ❑ N	❑ Other
				❑ Y ❑ N	
				❑ Y ❑ N	
				❑ Y ❑ N	

ALL household members must be enrolled for coverage. Please attach additional pages if necessary.

Insurance Information	Primary	Secondary
Policy holder's name		
Policy holder's employer		
Insurance company name		
Insurance company address		
City, State, Zip		
Insurance company phone #		
Policy #		
Group #		

I, the undersigned, certify that the above information is correct and authorize any holder of medical information or documentation to release to the Health Care Financing Authority and its agents, carriers, third party payers and insurers, and to Champion EMS, any information or documentation needed to process insurance claim(s) for services provided to me or any member of my household by Champion EMS, now or in the future. I further authorize direct payment of any insurance benefits to Champion EMS and will forward any medical transportation insurance benefits received by me to Champion EMS. I understand that the Membership Program covers only calls that are deemed "Medically Necessary." This determination is typically made by the "Primary Insurance Carrier." Champion EMS accepts the carrier's determination of covered and non-covered charges as a professional non-biased opinion of "Medically Necessary." My membership will cover the remaining balance of expenses deemed "Medically Necessary," after payment is received from my insurance(s). MEMBERS WHO DO NOT HAVE INSURANCE WILL RECEIVE 40% DISCOUNT FOR "MEDICALLY NECESSARY" SERVICES AND ARE RESPONSIBLE FOR THE REMAINING 60% OF THE BILL. New membership cards will be sent once your payment is confirmed. Cards do not have to be presented at the time of service. Your canceled check or credit card bill will serve as your receipt of payment. **PLEASE NOTE: MEDICAID RECIPIENTS ARE NOT ELIGIBLE PER TEXAS STATE STATUTE.** If you have any questions, please call (903) 291-3000 or toll free (877) 925-2273.

Check one or both: I/We work in Champion EMS service area ❑ live in Champion EMS service area ❑

Member Signature _____ ***Date*** _____

Payment Amount: $ _____ ($60 per household per year. If joining plan mid-year, price is prorated $5 per month.)
Please mail your payment & application to: Champion EMS, 2201 S. Mobberly Ave., Longview, TX 75602.

PLEASE CHECK ONE: ❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ MONEY ORDER ❑ PERSONAL CHECK

NAME ON CREDIT CARD & BILLING ADDRESS: _____

_____

_____

CARD NUMBER: _____ EXPIRATION DATE: _____ CVV CODE (BACK OF CARD): _____

Champion EMS is a non-profit entity and wholly owned subsidiary of the CHRISTUS Health System