REACH℠ Air Medical Services

Mountain Communities Healthcare District
Trinity Life Support CSD

PHI CARES
A service of PHI Air Medical

Trinity County Medical Transport Partnership Application

Medical Transport Partnership Annual Fee: **$150.00**

Name: _____ DOB: _____

Spouse/Partner: _____ DOB: _____

Mailing Address: _____

City _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Eligible Family Members: ***(You may list additional family members on a separate sheet.)***

Name:	Relationship:	Date of Birth:

NOTICES REQUIRED BY THE DEPARTMENT OF MANAGED HEALTH CARE:

(A)) BEFORE YOU PURCHASE: If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by TRINITY LIFE SUPPORT/MCHD, PHI, AND REACH may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly.

(B) WARNING: TRINITY LIFE SUPPORT/MCHD, PHI, AND REACH Medical Transport Partnership is not an insurance program. They will not compensate or reimburse another ambulance company that provides emergency transportation to the person(s) listed on this form. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service or is next in the rotation to receive a call. This might also occur when TRINITY LIFE SUPPORT/MCHD, PHI, AND REACH are unable to perform within a medically appropriate time frame due to a mechanical or maintenance problem or being on another call. **SIGN HERE:** _____

(C) COMPLAINTS: For complaints regarding TRINITY LIFE SUPPORT/MCHD, PHI, AND REACH, or if you have questions regarding the Plan, first attempt to call Mountain Communities Healthcare District Membership Coordinator at 530-623-2687 ext, 5001. If the complaint is not resolved to your satisfaction, contact the Department of Managed Health Care at 1-888-466-2219. The Department's website is **http://www.healthhelp.ca.gov**. You may obtain complaint forms and instructions online.

(D) OPERATING UNDER CONDITIONAL EXEMPTION: TRINITY LIFE SUPPORT/MCHD, PHI, AND REACH is operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq.).

INITIAL HERE: _____

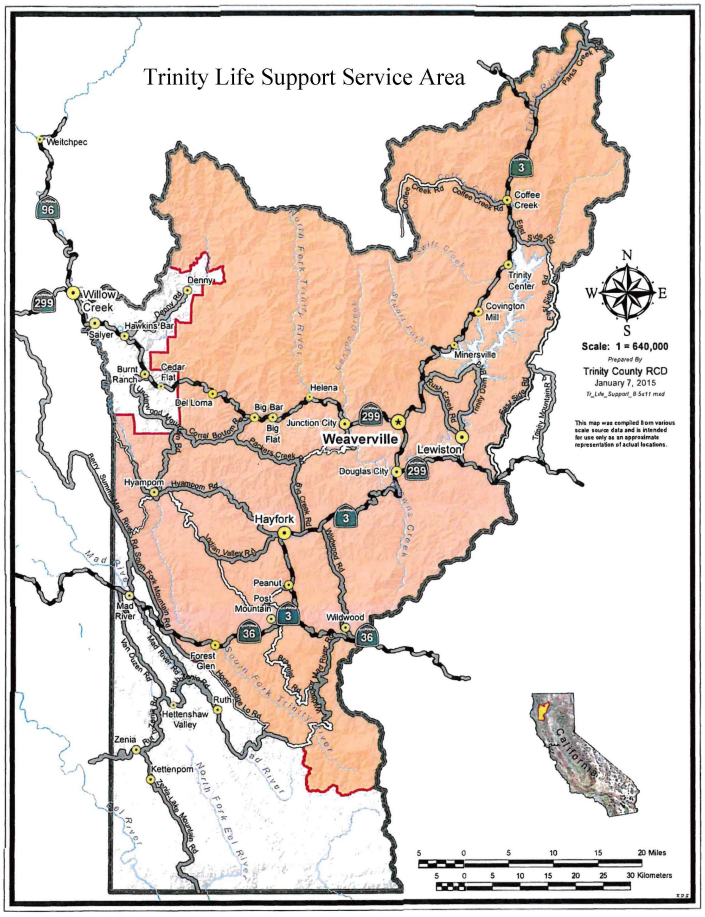
I hereby apply for membership in the Trinity County Medical Transport Partnership program. I understand that ambulance services and membership benefits will be provided according to the terms and conditions of each participating provider as follows:

Trinity Life Support/MCHD:

- **MEMBERSHIP BENEFITS:** Trinity Life Support/MCHD members pay nothing out of pocket for medically necessary ambulance services. Medical necessity is defined as a specific need for ambulance transportation to or from a healthcare facility (911 emergency or inter-facility transfer), where use of other forms of transportation would be medically inappropriate or detrimental to the patient.
  I understand that Trinity Life Support/MCHD can require physician certification of medical necessity.
  I understand that membership is not an insurance policy, nor is it meant to be a substitute for health insurance. It does not compensate another ambulance company providing service to me or my family. I understand this might occur when Trinity Life Support/MCHD is unable to respond within a medically appropriate time frame due to unexpected high call volume, road closures, or vehicle problems.

- **PERSONS COVERED:** I understand that my membership covers those persons who permanently reside in my household. A "household" is defined as all persons who permanently reside at the "Head of Household's" physical address. New household members may be added, household members may be deleted or the household location may be changed by written notice to Trinity Life Support/MCHD, effective the day following receipt by Trinity Life Support/MCHD of such notice.
  I understand if I have Medi-Cal or Medicaid, I have full coverage and do not need membership.

- **SERVICE AREA: The Service Area for Trinity Life Support/MCHD is shown at right, in tan shading, and includes the towns of**: Big Bar, Big Flat, Coffee Creek, Covington Mill, Del Loma, Douglas City, Forest Glen, Hayfork, Helena, Hyampom, Junction City, Lewiston, Minersville, Peanut, Post Mountain, Trinity Center, Weaverville, and Wildwood. I understand membership is available only to residents within the Trinity Life Support/MCHD primary service area.



- **ASSIGNMENT OF BENEFITS:** I understand that my membership is not an insurance plan and that Trinity Life Support/MCHD will bill and receive payments from my insurance for the balance. This may include medical, health, supplemental workers' compensation, liability, auto or homeowner's insurance policies and plans, Medicare, and/or other third party payers. I hereby assign all such insurance benefits or payments for ambulance services covered by this agreement to Trinity Life Support/MCHD.
  I understand that if I receive direct insurance payment for ambulance service provided, I will immediately forward that payment to Trinity Life Support/MCHD. If I do not, I understand my membership may be terminated and I would then be billed full charges for services received.
  I also understand that abuse of the service, if found to exist, may result in termination of membership.

- **EFFECTIVE DATES & RENEWAL:** Membership is effective within seven (7) business days of receipt of payment. The waiting period will be waived for unforeseen events.
  Membership fees and services are subject to periodic review and update**.** Any benefit modification and/or rate change will be outlined and applied at annual renewal.
  Memberships are non-transferrable.

- **LIFETIME SIGNATURE AUTHORIZATION:** To facilitate processing, I authorize the release to Trinity Life Support/MCHD, 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 Trinity Life Support/MCHD. I permit a copy of this authorization to be used in place of the original.

INITIAL HERE: _____

PHI:

AGREEMENT FOR MEMBERSHIP: This Air Ambulance Membership Plan Coverage Agreement ("Agreement") is entered into between PHI Inc., doing business as PHI Air Medical (referred to herein as "PHI Air Medical"), based at 801-D Airport Way, Modesto, CA 95354, and based at 10713 Airport Rd, Columbia, CA 95310, and doing business as Mercy Air Ambulance (referred to herein as "Mercy Air"), based at, 5900 Old Oregon Trail, Redding, CA 96002, and the signatory on the 2011-2012 PHI Air Medical / Mercy Air Membership Plan Application ("Application"). The Membership Office is located at 2800 N 44th St Suite 800, Phoenix AZ.

By signing the Application, I agree, on behalf of myself and the residents of my household listed on the Application, to abide by the terms of PHI Air Medical / Mercy Air's 2010-2011 Ambulance Membership Plan (the "Plan"), as set forth in this Agreement. Coverage will begin five (5) days after PHI Air Medical / Mercy Air receives my application and payment, and will expire midnight on the last day of the month payment is received of the following year. There is no waiting period for renewal applications.
PERSONS COVERED: The Plan covers me and the household members listed in my Application, so long as they remain full-time residents of the specified household. New household members may be added, household members may be deleted or the household location may be changed by written notice to PHI Air Medical / Mercy Air, effective the day following receipt by PHI Air Medical / Mercy Air of such notice. All persons covered by the Plan shall be referred to herein as "Plan Members" or "Members." References to "I" or "me" and similar references shall be construed as including all Members.
CONDITIONS OF MEMBERSHIP: As a condition of obtaining the benefits of membership and Plan coverage, I must submit a complete, accurate Application and pay PHI Air Medical / Mercy Air a non-refundable membership fee in the amount specified in the Application. In the event of any change in the insurance coverage or status of any individual named in the Application, I agree to notify PHI Air Medical / Mercy Air within ten (5) days and, if the change results in the affected individual owing an additional membership fee, I agree to pay the additional amount upon receipt of an invoice from PHI Air Medical / Mercy Air.

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by PHI Air Medical /Mercy Air, but that my membership in the Plan will assist me by discharging that part of my financial liability that is not covered by insurance for those PHI Air Medical / Mercy Air services specified in this Agreement. This benefit is subject to certain limitations specified in this Agreement. As a condition of receiving this benefit, I hereby assign to PHI Air Medical / Mercy Air all rights and benefits that I or the other Members in my household have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for air ambulance services covered by this Agreement. Such payment sources are collectively referred to in this Agreement as "Insurance." I authorize payment of all Insurance benefits or payments for ambulance services covered by this Agreement to PHI Air Medical / Mercy Air.

I understand that PHI Air Medical / Mercy Air will, whenever it deems it feasible, file claims for and directly collect the benefits payable from Insurance, up to the amount of PHI Air Medical / Mercy Air's charges for its services. When requested by PHI Air Medical / Mercy Air, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receives any Insurance or other third party payments for air ambulance services provided by PHI Air Medical / Mercy Air, I will promptly turn over those payments to PHI Air Medical / Mercy Air. I agree to pay PHI Air Medical / Mercy Air for any services it provides that are not covered by this Plan.
BENEFITS: Payment of the membership fee and compliance with the terms of this Agreement entitle Members to the following benefits within the Service Area as specified below:
a. Emergency air ambulance services: Members who receive medically necessary emergency air ambulance services from PHI Air Medical / Mercy Air shall pay nothing out of pocket, except as specified herein.
b. Inter-facility air ambulance services. Members who receive medically necessary inter-facility air ambulance services from PHI Air Medical / Mercy Air shall pay nothing out of pocket, except as specified herein.
LIMITATIONS and EXCLUSIONS: Membership benefits only extend to medically necessary rotary wing (helicopter) and fixed wing (airplane) air ambulance services provided by PHI Air Medical / Mercy Air provided in the Service Area as described below. No benefits are provided for ground ambulance services, even if provided as a means of facilitating air ambulance services. Subject to the foregoing, in determining whether any emergency or inter-facility air ambulance service is "medically necessary," PHI Air Medical / Mercy Air reserves the right to require a certificate of medical necessity from a qualified physician in determining medical necessity. As a condition of receiving the full benefit of membership with respect to any ambulance service provided by PHI Air Medical / Mercy Air, the ambulance service must be covered by the Member's primary Insurance coverage. Some insurance programs require the insured person to obtain prior authorization before receiving ambulance services. Some plans require certain documentation from the insured within a specified time limit, or the plans deny or reduce coverage for ambulance services. Services outside the Service Area are or beyond the mileage limitations specified below are not covered. PHI Air Medical / Mercy Air shall apply the standards of the Medicare program. **Medi-Cal participants are not eligible for membership.**

SERVICE AREA: The Service Area for California covers the Counties of: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn. Humboldt, Inyo, Kings, Tulare, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba, and other counties within the continental United States, in which PHI Air Medical / Mercy Air has a full-time air ambulance base. Only the first 200 miles of rotary-wing (helicopter) transport are covered. Only the first 600 miles of fixed-wing (airplane) transport, which shall be deemed to be within the Service Area are covered.
TERMINATION AND RENEWAL OF COVERAGE: PHI Air Medical / Mercy Air may terminate this Agreement and the participation of any Membership the Plan for failure to comply with the terms of this Agreement. PHI Air Medical / Mercy Air reserve the right to discontinue its Ambulance Plan at any time upon notice to Members. In such event, PHI Air Medical / Mercy Air shall return a pro rata portion of the membership fee. PHI Air Medical / Mercy Air also reserves the right to unilaterally modify the terms of this Plan, including but not limited to the membership fee to be charged to Members who join or renew their membership after the effective date of such change. Subject to the foregoing, PHI Air Medical / Mercy Air shall renew membership on an annual basis upon completion by a Member of an Application or Renewal Application and payment of the specified Membership Fee. Renewal contracts may include changes in coverage.

INITIAL HERE: _____

REACH Air Medical Services/AMCN:

AirMedCare Network is an alliance of affiliated air ambulance providers* (each a "Company"). An AirMedCare Network membership automatically enrolls you as a member in each Company's membership program. Membership ensures the patient will have no out-of-pocket flight expenses if flown by a Company by providing prepaid protection against a Company's air ambulance costs that are not covered by a member's insurance or other benefits or third party responsibility, subject to the following terms and conditions:

1. Patient transport will be to the closest appropriate medical facility for medical conditions that are deemed by AMCN Provider attending medical professionals to be life- or limb-threatening, or that could lead to permanent disability, and which require emergency air ambulance transport. A patient's medical condition, not membership status, will dictate whether or not air transportation is appropriate and required. Under all circumstances, an AMCN Provider retains the sole right and responsibility to determine whether or not a patient is flown.

2. AMCN Provider air ambulance services may not be available when requested due to factors beyond its control, such as use of the appropriate aircraft by another patient or other circumstances governed by operational requirements or restrictions including, but not limited to, equipment manufacturer limitations, governmental regulations, maintenance requirements, patient condition, age or size, or weather conditions. FAA restrictions prohibit most AMCN Provider aircraft from flying in inclement weather conditions. The primary determinant of whether to accept a flight is always the safety of the patient and medical flight crews. Emergent ground ambulance transport of a member by an AMCN Provider will be covered under the same terms and conditions.

3. Members who have insurance or other benefits, or third party responsibility claims, that cover the cost of ambulance services are financially liable for the cost of AMCN Provider services up to the limit of any such available coverage. In return for payment of the membership fee, the AMCN Provider will consider its air ambulance costs that are not covered by any insurance, benefits or third party responsibility available to the member to have been fully prepaid. The AMCN Provider reserves the right to bill directly any appropriate insurance, benefits provider or third party for services rendered, and members authorize their insurers, benefits providers and responsible third parties to pay any covered amounts directly to the AMCN Provider. Members agree to remit to the AMCN Provider any payment received from insurance or benefit providers or any third party for air medical services provided by the AMCN Provider, not to exceed regular charges. Neither the Company nor AirMedCare Network is an insurance company. Membership is not an insurance policy and cannot be considered as a secondary insurance coverage or a supplement to any insurance coverage. Neither the Company nor AirMedCare Network will be responsible for payment for services provided by another ambulance service.

4. Membership starts 15 days after the Company receives a complete application with full payment; however, the waiting period will be waived for unforeseen events occurring during such time. Members must be natural persons. Memberships are non-refundable and non-transferable.

5. Some state laws prohibit Medicaid beneficiaries from being offered membership or being accepted into membership programs. By applying, members certify to the Company that they are not Medicaid beneficiaries.

6. These terms and conditions supersede all previous terms and conditions between a member and the Company or AirMedCare Network, including any other writings, or verbal representations, relating to the terms and conditions of membership.

*Air Evac EMS, Inc. / EagleMed LLC / Med-Trans Corporation / REACH Air Medical Services, LLC — These terms and conditions apply to all AirMedCare Network participating provider membership programs, regardless of which participating provider transports you.

INITIAL HERE: _____

I acknowledge that I have reviewed and agree to abide by the terms and conditions of each participating provider as described above.

SIGN HERE: _____ **DATE**: _____

Trinity County Medical Transport Membership – Payment Sheet

Annual Medical Transport Membership Payment: $150.00 **(Please make checks payable to MCHD)**

☐ Cash ☐ Check ☐ Money Order ☐ Visa

Credit Card #: _____ Exp. Date: _____ Security Code: _____

Name on Credit Card: _____

Signature of Cardholder: _____ **Date**: _____

To enroll, please send your completed application, payment and proof of Trinity County residence to Mountain Communities Healthcare District:

Trinity Life Support/MCHD
TRACKING #: 003
PHI
TRACKING #:3639

Membership Coordinator
MCHD Admin Office
P.O. Box 1229
Weaverville, CA 96093
Phone: 530-623-2687 ext. 5001

REACH
TRACKING #: 12952
CODE #: 016