



# LOWER ALLEN TOWNSHIP EMERGENCY MEDICAL SERVICES

## 2024 Ambulance Subscription



***“Serving You for Life”***

**LOWER ALLEN TOWNSHIP EMS PROVIDES  
BASIC, INTERMEDIATE AND ADVANCED LIFE SUPPORT 24/7/365**

Lower Allen Township EMS faces continual challenges because of uncontrolled inflation affecting every aspect of health care cost and rising labor cost, along with increased call volume and reduced availability of EMS resources. Lower Allen Township EMS selflessly serves as the medical safety net for the citizens of Lower Allen Township. EMS is the tip of the medical response spear for medical emergencies, trauma injuries, pandemics, and disasters. EMS subscriptions help us continue to provide the highest quality of basic, intermediate, and advanced life support. Your subscription fee directly supports our 2024 budget expenditures of nearly \$2 million dollars to ensure the physical and mental health of you and your loved ones living in Lower Allen Township. These expenses are partially funded through insurance reimbursements for ambulance services, donations and our annual subscription drive.

The EMS division provides emergency pre-hospital care and ambulance transportation to hospital emergency care units for residents and visitors in our community. In addition to this vital service, the EMS staff is very active as emergency care trainers, doing public visitations / speaking engagements, and disaster planning sessions with area businesses and health care facilities.

The EMS subscription drive is conducted annually during the fall and winter months by the EMS division. The subscription provides the residents an opportunity to assist us in equipping our ambulances with the finest quality medical equipment.

***We appreciate your past support and stand ready  
to serve you, if or when the time is needed.***

**In the Event of an Emergency**



### **What to Tell the 911 Dispatcher:**

- Your name
- Your address
- Your telephone number
- What happened
- Any special landmarks or cross streets
- Any other pertinent information

### **When Should You Call 9-1-1?**

- Is or becomes unresponsive
- Have chest pain or pressure
- Have difficulty breathing
- Any slurred speech
- Severe headache
- Any vision changes
- Any changes in mental state
- Bleeding severely
- Passing or vomiting blood
- Any seizure activity
- Head, neck or back pain
- Any traumatic injury
- If you have any doubts

*To provide the citizens and visitors of Lower Allen Township with the full spectrum of Pre-hospital care;  
executing the mission with compassion and competence, as a fully integrated public safety model.*





# LOWER ALLEN TOWNSHIP EMERGENCY MEDICAL SERVICES

## 2024 Ambulance Subscription

### SUBSCRIPTION TYPES

Lower Allen Township EMS offers two types of subscription:

- **Individuals: \$80** - One person living in a single residence
- **Households: \$100** - Includes the head of household, spouse and dependent persons living at the residence

### SUBSCRIPTION TERM

Our program runs calendar year, Jan 1 to Dec 31. Your 2024 subscription is valid from the date of payment through Dec 31, 2024.

### SUBSCRIPTION COVERAGE & BENEFITS

The Lower Allen Township EMS subscription provides the following coverage for each individual within a household per calendar year:

- **The co-pay/co-insurance for the first ambulance transport will be covered 100% by the subscription** (Note: Payment after the first ambulance transport will be the responsibility of the patient.)

Your subscription also includes:

- **Medically Necessary Emergency Transportation** to the closest appropriate hospital.
- **Basic Life Support, Intermediate** and **Advanced Life Support** Lower Allen Township EMS provides all levels of care.
- **Free CPR Training** for immediate family members

### WHAT IS THIRD-PARTY BILLING & HOW DOES IT WORK?

Third-party billing is the process whereby Lower Allen Township EMS bills federal and state entitlement programs such as Medicare and Medicaid, as well as commercial insurers. If necessary, we will also bill patients directly if they lack insurance.

Unfortunately, some commercial carriers issue a check directly to the patient. In such cases, the patient is obligated to immediately endorse the check over to Lower Allen Township EMS, along with the corresponding Explanation of Benefits (EOB). If a patient keeps such a check, the membership is invalidated and we reserve the right to pursue collections through all legally permissible avenues.

It's important to note that Lower Allen Township EMS does not participate in the direct commercial insurance payment program. You are responsible for the full amount of the Lower Allen Township EMS charges billed. If your insurance does not pay in full, you are responsible for either filing an appeal or paying the balance. If you fail to pay we reserve the right to pursue collections.

### 2024 SUBSCRIPTION RECORD

Subscription cards are not issued.  
Please retain this document for your records.

Check #

Date

Amount

Subscription Level

Donation

*To provide the citizens and visitors of Lower Allen Township with the full spectrum of Pre-hospital care; executing the mission with compassion and competence, as a fully integrated public safety model.*



# LOWER ALLEN TOWNSHIP EMERGENCY MEDICAL SERVICES

## 2024 Ambulance Subscription Request Form

### IMPORTANT -- PLEASE NOTE:

**If you do not have health care coverage or your health care coverage does not cover ambulance transportation, or you are a Medicaid recipient, you are not eligible to become a subscriber.**

**Please complete all steps of this application, including both FRONT and BACK. Incomplete forms will be returned.**

### STEP 1: SUBSCRIPTION LEVEL

*Please check the appropriate level subscription level, as well as, any additional donation amount*

- ☐ Individual \$80.00  
☐ Household \$100.00  
☐ Donation \$ \_\_\_\_\_  
Total Amount \$ \_\_\_\_\_

Make check payable to: Lower Allen Township EMS, 2233 Gettysburg Rd, Camp Hill, PA 17011

### STEP 2: CONTACT INFORMATION

*Please provide your contact information, along with any additional household members*

Primary Household Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Additional Household Members: \_\_\_\_\_

### STEP 3: SPECIAL NEEDS

*Do any household members require special assistance, should an emergency evacuation become necessary? We request that you update any special needs information, each year.*

- ☐ No  
☐ Yes - Please provide the household member's name and needs: \_\_\_\_\_

### STEP 4: SIGNATURE ACKNOWLEDGEMENT

*By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of this subscription program and I hereby apply to be a subscriber of Lower Allen Township.*

I apply for participation as a subscriber in the subscription program of Lower Allen Township. I agree to the terms and conditions of the subscription described above. I verify that I am not a Medicaid recipient or an individual who does not have health care coverage or an individual whose health insurance does not cover ambulance transportation. I request payment of authorized Medicare or any other insurance benefits be made on my behalf to Lower Allen Township for any ambulance services provided to me by Lower Allen Township now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Lower Allen Township. I understand that I may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Lower Allen Township any payments that I receive directly from my insurance or any source whatsoever for the services provided to me and I assign all right to such payments to Lower Allen Township.

Signature of Primary Subscriber: \_\_\_\_\_ Date: \_\_\_\_\_

**TURN OVER FOR STEP 5: INSURANCE INFORMATION >>>**

# LOWER ALLEN TOWNSHIP EMERGENCY MEDICAL SERVICES

## 2024 Ambulance Subscription Request Form Continued

### IMPORTANT -- PLEASE NOTE:

**If you do not have health care coverage or your health care coverage does not cover ambulance transportation, or you are a Medicaid recipient, you are not eligible to become a subscriber.**

### STEP 5: INSURANCE INFORMATION

Please complete the appropriate section or sections. Health insurance information is needed for each household member.

Complete this section if **TRADITIONAL MEDICARE** is your primary coverage

Medicare ID # (MBI): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Medicare ID # (MBI): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Complete this section with your **SUPPLEMENTAL INSURANCE** to Traditional Medicare

Insurance Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID # (Include Alpha Prefix): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID # (Include Alpha Prefix): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Complete this section if a **MEDICARE ADVANTAGE PLAN** is your primary coverage  
(i.e. Aetna Golden, Highmark Freedom Blue, Humana, etc.)

Insurance Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID # (Include Alpha Prefix): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID # (Include Alpha Prefix): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Complete this section if a **COMMERCIAL CARRIER** is your primary coverage  
(i.e. Aetna, Capital Blue Cross, Highmark Blue Shield, etc.)

Insurance Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID # (Include Alpha Prefix): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Names of all household members covered under this insurance: \_\_\_\_\_

Complete this section with any **OTHER INSURANCE**

Insurance Carrier Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID # (Include Alpha Prefix): \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Names of all household members covered under this insurance: \_\_\_\_\_