



Dear Area Resident,

As our annual subscription drive begins this year we would like to take a moment to thank you for your support throughout the year. It is our pleasure to serve Clarion County and the surrounding communities. We are asking that you consider purchasing a subscription to our ambulance service for 2021-2022.

As reimbursement rates decline and healthcare reform continues at a rapid rate, we are responding with changes in order to continue to serve our community well into the future. For the 2021 subscription plan the following changes have been made:

- If your insurance denies payment for the ambulance trip due to “not being medically necessary” you will receive a bill. With the purchase of a subscription, these calls will be at a reduced rate.
- If you call for our services and choose to refuse to be transported for further treatment, you may receive a bill. With the purchase of a subscription, these calls will be at a reduced rate.
- If you choose to be transported to a facility that is not the closest to you, your insurance company may only pay the mileage to the closest facility. If your insurance company denies the fee, you will be responsible to pay any uncovered mileage. Your subscription covers the first 10 miles at no charge.
- The subscription fee does not cover the actual cost of service, please be aware that your subscription does not cover any deductibles that are charged by your insurance company. Deductibles are put in place by insurance companies - this is a fee that the patient is responsible to cover.
- To be clear, this is not an insurance policy

All renewed subscriptions will become effective on July 1, 2021 and will remain in effect through June 30, 2022. When the time comes that an ambulance is needed, be sure that you are a subscription holder.

WHEELCHAIR VAN SERVICES

Wheelchair van transportation service is also available from Clarion Hospital EMS, however **it is not covered by the ambulance service subscription program, Medicare or Medicaid, and most private insurance.** We are offering a reduced wheelchair van rate to our subscribers. The wheelchair van base rate for our subscribers is \$20.00 per trip (non-subscriber rate is \$30.00 per trip). There is additional mileage charge for over 10 miles. The stretcher van service is available at \$270.00 per trip and \$10.00 per loaded mile. We ask you to consider Clarion Hospital EMS if you need this type of alternative transportation service.

Please complete the enclosed subscription application form and return it with payment in the postage-paid envelope, which we have provided for you.

For your convenience, you may access the ambulance subscription online at www.clarionhospital.org. Simply, click on services, and then click on Clarion Hospital EMS, print out the application and return it to us.

As a reminder, please sign and cut the bottom portion of the subscription renewal for your records

Some of our members have asked about giving donations to our Ambulance Service, we would be happy to accept donations that you would like to give.

If we can be of any assistance to you, or can answer any questions you have, please do not hesitate to contact our offices at 814-226-1248 or toll free at 1-800-522-0505, extension 1248. We sincerely look forward to serving as your ambulance service in the coming year. We thank you for your contribution.

Sincerely,

Don Hosey, Paramedic, RN, Emergency Services Manager



Subscription / Renewal Notice 2021-2022

Subscription Plans (check one)

- | | | | |
|--|------|---|------|
| <input type="checkbox"/> Household | \$60 | <input type="checkbox"/> Couple 65 & up | \$40 |
| <input type="checkbox"/> Individual under 65 | \$50 | <input type="checkbox"/> Individual over 65 | \$35 |

Name: _____ Phone: (____) _____ - _____

Address: _____

City, State, Zip: _____

Subscription Amount \$ _____ Donation \$ _____ Total \$ _____

Make checks payable to: Clarion Hospital EMS (1 Hospital Drive Clarion, PA 16214)

Sign & Return This Completed Form With Payment

Covered Household Family Members:

Name:	Date of Birth:
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

Authorization:

I authorize that payment of authorized Medicare Benefits or other insurance benefits be made on my behalf to Clarion Hospital for any ambulance service provided to me by Clarion Hospital EMS. I authorized any holder of medical information or documentation about me to release to the Health Care Financing Administration and its carriers and agents, as well as to Clarion Hospital and any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Clarion Hospital EMS now or in the future.

Head of Household Signature: _____

