



The ESP Membership Program is a family protection plan offered by Southwestern Michigan Community Ambulance Service (SMCAS). For just \$45.00 a year, ESP members pay no additional out-of-pocket costs for *(medically necessary) ambulance service they may require during the year.

ESP Memberships are available to residents of Niles City, Buchanan City, Niles Township, Buchanan Township, Bertrand Township, Howard Township, and Pokagon Township (Sections 25-36).

Effective Dates:

Memberships will be accepted throughout the calendar year & will be effective upon receipt of payment to SMCAS and will expire 1 year from date of enrollment.

If I have insurance, who receives claim payments:

SMCAS-ESP Program is not insurance and SMCAS will pursue claim payments from your insurer or third party agency (e.g. Medicare, Medicaid, Blue Cross/ Blue Shield, etc.). To help process claims, I authorize release of any medical information necessary to process a claim, and further authorize such payment to be made directly to Southwestern Michigan Community Ambulance Service (SMCAS). If your insurance carrier makes payments directly to you, you are responsible for making payment to SMCAS.

If I have no insurance:

SMCAS-ESP Program is not insurance and SMCAS will bill you a minimal \$200 co-payment for services rendered. You are responsible for payment of these co-payment amounts to SMCAS.

***What is medically necessary:**

SMCAS-ESP Membership Services are restricted to “medically necessary” defined as “the specific need for ground ambulance service transportation to or from a health care facility (hospital or nursing home), where use of alternate forms of transportation (wheelchair transports, private car, Dial-a-Ride, taxi) would be medically inappropriate given the patient’s condition”. All calls must originate within the service area or servicing hospitals. SMCAS will utilize the guidelines set by insurance carriers to establish medical necessity and reserves the right to require physician certification of the medical necessity. If you abuse your membership, your membership will be revoked. Non-emergency ambulance and wheelchair transfers are not covered under the SMCAS-ESP Program.

If services are needed outside the SMCAS Service Area:

Out-of-area ambulance services are **not** covered by the ESP Program. If you move out of the service area (as detailed above) your membership will be void.

Who in my home is covered by this program:

The SMCAS-ESP Program covers those individuals residing in your household that you can claim as a dependent on your Federal Income Tax Form. **YOU MUST USE THE SERVICES OF SMCAS IN ORDER TO QUALIFY FOR MEMBERSHIP BENEFITS.** This membership is non-refundable and non-transferable.

**FOR ADDITIONAL INFORMATION
CALL SMCAS AT (269) 684-2170
MONDAY – FRIDAY 8:00 AM – 5:00 PM
Retain this portion for your records.**



SMCAS-ESP MEMBERSHIP PROGRAM AGREEMENT AND APPLICATION

(Read Completely Before Signing)

Mail completed form and \$45 to:

SMCAS-ESP
2100 Chicago Road
Niles, MI 49120

DO NOT SEND CASH

Subscriber: _____

Address: _____

City: _____

(Eligible if a resident of the following, please check appropriate box)

- | | | | |
|--------------------------------------|----------------------------------------|----------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Howard Twp. | <input type="checkbox"/> Bertrand Twp. | <input type="checkbox"/> Pokagon Twp.
Sec 25-36 | <input type="checkbox"/> Niles Twp. |
| <input type="checkbox"/> Niles City | <input type="checkbox"/> Buchanan City | <input type="checkbox"/> Buchanan Twp. | |

Home Phone: _____ Work Phone: _____

Soc. Sec. #: _____ Date of Birth: _____

Please list information for each eligible dependent.
(Attach separate list if necessary) Indicate relationship of household members listed:
H-husband; W-wife; S-son; D-daughter.

Name	Date of Birth	Soc. Sec. #	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Return with Payment

MEDICARE

Your Medicare # _____

Spouse's Medicare # _____

HEALTH INSURANCE

Employer: _____

Insurance Company: _____

Insurance Claims Address: _____

Policy ID#: _____ Group #: _____

Spouse's Employer: _____

Insurance Company Name: _____

Insurance Claims Address: _____

Policy ID#: _____ Group #: _____

NO INSURANCE – I have no health insurance _____

Subscriber Signature: _____
Date: _____

Spouse's Signature _____
Date: _____

Membership contract must be signed. Membership is non-transferable and non-refundable.

**FOR ADDITIONAL INFORMATION CALL SMCAS AT 684-2170
MONDAY – FRIDAY 8:00 AM – 5:00 PM**