CareFlite
3110 S. Great Southwest Parkway
Grand Prairie, TX 75052
Fax (972) 352-6634

Caring-Heart
CareFlite's Membership Program
(877) 339-2273

Town of Cross Roads
3201 US 380, STE 105
Cross Roads, TX 76227
Phone (940) 365-9693

A one year Caring-Heart Membership has been purchased on your behalf by the Town of Cross Roads. Please fill out this form and return to Town Hall.

First Name: ______________________________ Middle Initial: ___ Last Name: ________________________________

Home Address: ____ City: _____________________________________

Zip: _____________ County: _______________________________ Home Phone #: ____________________________

Date of Birth: _____________ □ Male □ Female

Employer Name: ____

Primary Insurance: □ No □ Yes, if yes, Insurance name _________________________________

Supplement Insurance: □ No □ Yes, if yes, Insurance name _________________________________

Other Family Members of Household *(For additional household family members, please copy this page and attach to this application).*

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: ________________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: ________________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: __________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: __________________________

First Name: _________________ Middle Initial: _____ Last Name: ________________________________

Date of Birth: ____________________ □ Male □ Female

Primary Insurance: □ No □ Yes, if yes, Insurance name: __________________________

By Paying the CareFlite Membership fee I agree (on behalf of my family) to abide by the terms and wish to hereby apply for Air Membership in the CareFlite Caring Heart Membership Program for myself and members of my household listed on the Application, as set forth in this Agreement. I have reviewed the Caring-Heart Air Membership Agreement and agree to abide by the terms thereof. I request payment of authorized Medicare or other insurance benefits to me, or on my behalf, to be paid to CareFlite for any emergency services and supplies furnished to me by CareFlite. I authorize any holder of any of any of my medical information to release that information to the CMS, its agents and carriers, or CareFlite, in order to determine benefits payable on my behalf, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of the other members of my household, if they are minors or otherwise unable to sign. I understand that under the State rule 157.11 k, if I or a household member is a Medicaid recipient, then I am not allowed to have them on my Application, therefore, I am stating that I have not listed on my application anyone that is a Medicaid recipient. If a family member becomes a recipient of Medicaid, I will notify CareFlite in writing of this life change immediately. I warrant that all the information in the Application is true and correct. CareFlite reserves the right to request documentation demonstrating the accuracy of such information. I acknowledge that membership in CareFlite Caring-Heart Membership Program is simply a membership in a program sponsored by CareFlite, and thus, is not membership in CareFlite's non-profit corporate entity as the term membership is contemplated under the Texas Non-Profit Corporation Act.

For CareFlite Office Use Only:
Date Received: _________ Form of Payment: ________ EE ID# ________
Amount Paid: _____________ Membership Number Assigned: __________________

Caring-Heart

Membership Program

PERSONS COVERED: This Agreement covers the household family members listed on my Application, so long as they remain full-time residents of the specified household. New residence family members may be added, family members may be deleted or the household location may be changed by written notice to CareFlite. Added members will be effective immediately as of the postmarked date on the envelope. I understand that Medicaid recipients are not permitted to enroll in this program.

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by CareFlite, but that my membership will assist me by discharging that part of my financial liability that is not covered by insurance for those CareFlite services specified in this Agreement. This benefit is subject to certain limitation specified in this agreement. As a condition of receiving this benefit, I hereby assign (hand over) to CareFlite all rights and benefits that I or the other family members of my residence 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. Such payment sources are collectively referred to in this agreement as 'insurance.' I authorize payment of all insurance benefits or payments to CareFlite. I understand that CareFlite will, whenever it deems it feasible, file claims for and directly collect the benefits payable from insurance, up to the amount of CareFlite's charges for its services. When requested by CareFlite, 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 Emergency services provided by CareFlite, I will promptly forward those payments to CareFlite at 3110 S. Great Southwest Parkway, Grand Prairie, Texas 75052.

BENEFITS: Payment of membership fee and compliance with the terms of this Agreement entitles members to the following benefits:
a. Emergency air ambulance services: Members, who receive "medically necessary" advanced or basic life support emergency services from CareFlite as a result of an emergency medical condition,' shall pay nothing out of pocket, except as specified herein.
b. Emergencies needing a higher level of care located further than 100 miles away but not more than 500 miles and in the U.S. can be serviced by CareFlite's Fixed Wing. All medical transports must meet the medical criteria and be pre-approved by patients insurance carrier before services can be provided.

Upon services being approved and used, the member will pay nothing out of pocket. If insurance coverage is denied then member will be responsible for full charges less a 50% discount off of usual and customary charges for such services.

LIMITATIONS and CONDITIONS: Membership benefits extend to CareFlite's critical care, advanced or basic life support air ambulance services staffed with Nurses, Paramedics and Pilot's, Ground Ambulance staffed with quality trained Medics, and a 20% discounted rate for Wheelchair and transport Services. Membership benefits are inapplicable to services rendered by any other provider. As a condition of receiving the benefits of membership with respect to any Air or Ground ambulance transport, a member with insurance must comply with all coverage conditions of their applicable insurance program for such transport. Some insurance programs require the insured person to obtain prior authorization of payment for non-emergency, yet medically necessary air ambulance services. Non-insured household family members will receive a 50% membership discount on CareFlite's standard charges for the services rendered. Some plans require certain documentation from the insured within a specified time limit, or the plans deny or reduce coverage for air ambulance services. In the event a member with insurance forfeits coverage by failing to comply with these types of requirements for a transport that would otherwise be covered by membership, member will then forfeit membership benefit by failing to comply with their insurance requirements and membership can be revoked. Air Membership will only be available for purchase to residents of approved counties. For a current list of Counties where the Caring-Heart Membership is available, please visit www.careflite.org and click on: *become a member.* In addition, Ground benefits will cover those members in CareFlite service areas where applicable. The members must hold a membership that is in good standings at the time of services and the transport originates in CareFlite's deemed service area and providing that CareFlite is the transporting agency. CareFlite reserves the right to deny or revoke any membership for a reasonable cause. If membership is revoked then all balances are due in full. CareFlite may terminate the membership program at any time upon notice to the members, with a pro-rated portion of the membership fees refunded. To protect member fees, CareFlite maintains a bond with Hartford Casualty, an A+ rated insurance company.