



NATIONAL AIR AMBULANCE MEMBERSHIP APPLICATION

GROUP NAME (If Applicable): _____

SEE IMPORTANT NOTICES ON PAGE 2 PRIOR TO PURCHASE

Mailing Address _____ City _____ State _____ Zip _____

Home Phone #: (____) _____ Alternative Phone #: (____) _____

Email (optional) _____

Head of Household

First Name: _____ MI _____ Last Name: _____

Date of Birth _____ Does this member have medical insurance? Yes No

List all additional members of household. Please attach a separate sheet of paper if necessary.

First Name: _____ MI _____ Last Name: _____

Date of Birth _____ Does this member have medical insurance? Yes No

First Name: _____ MI _____ Last Name: _____

Date of Birth _____ Does this member have medical insurance? Yes No

First Name: _____ MI _____ Last Name: _____

Date of Birth _____ Does this member have medical insurance? Yes No

Annual Membership Fees

Plan Types	1-Year
Household w/medical insurance	\$50
Household with no medical insurance	\$100
Group Rates	Call Membership Office For Details

Mail To:
PHI Cares
P.O. Box 731886
Dallas, TX 75373-1886

Office Use Only			
Base Code		Track Code	

CALL TOLL-FREE
1.888.435.9744
 Mon-Fri 8AM to 4PM (MST)
WWW.PHICARES.COM

No Cash Payments

Acceptable methods of payment: Check Money Order
 Visa Mastercard Discover American Express

Credit Card: # _____ Expiration Date _____ Security Code _____

Signature of cardholder _____ Date _____

PHI CARES – MEMBERSHIP TERMS AND CONDITIONS

Membership

PHI Cares is a membership program operated by PHI which allows its members to access medically necessary air transports on PHI medically configured aircraft to the closest appropriate facility within 200 miles for a rotary-wing (helicopter) and 600 miles for a fixed-wing (airplane). The point of pickup must be within the PHI Cares service area. For a list of service areas, please see the PHI Cares website: www.phicare.com or contact the membership office directly. Membership is not an Insurance product and does not pay for services provided by other air or ground ambulance services. Membership is valid for one (1) year beginning five (5) days after your completed application and nonrefundable payment have been received and processed by the membership office. These terms also apply to renewing members that are more than thirty (30) days past their renewal date.

Billing

Members are charged an annual membership fee, which will vary based on whether or not you have healthcare insurance coverage. This annual membership fee is separate from any air medical transports actually undertaken by PHI Cares for such member.

A member who receives a medically necessary transport through the PHI Cares Program is responsible for payment, but is relieved of any financial responsibility for amounts that are not reimbursed by any available insurance. In other words, PHI Cares accepts what your insurance pays as “payment-in-full.”

PHI will bill your healthcare insurer or other third party directly for the air medical transport. Should you receive payment directly from your healthcare insurer or other third party payer, you agree to promptly remit such payment to PHI. If any third party or his/her insurer pays for the air transport charges either through settlement of a claim or a judgment, you agree to remit payment of the air medical transport charges to PHI.

Members who have no healthcare insurance coverage at the time of enrollment and no other third party payer to cover air medical transport charges will be released by PHI Cares from any payment for medically necessary air transport services.

PHI Cares members are responsible for and agree to pay for charges which are not covered by the PHI Cares membership, including but not limited to air transport pick-ups outside of the PHI Cares service area, air transport drop-offs beyond the geographic scope specified by PHI Cares, or any ground ambulance transportation services.

Eligibility & Availability

Medicaid participants are not eligible for PHI Cares membership.

*PHI aircraft may not be available at the time a flight request is made due to inclement weather, the aircraft is in service at the time of the request, the aircraft is undergoing maintenance or repairs, or other factors that make PHI aircraft unavailable for the request. You should inform the healthcare provider, dispatcher, or emergency personnel of your PHI Cares Membership at the time an air transport is requested, as these personnel will not be aware of your PHI Cares Membership.

Due to aircraft weight limitations, persons weighing in excess of 400 lbs. may not be able to access the PHI Cares Membership benefits, and PHI Cares does not recommend individuals who may fall into this weight category to become PHI Cares Members.

PHI, in consultation with other healthcare providers or dispatch agencies, reserves the right to determine whether air medical transport is medically necessary, safe, and appropriate under the circumstances.

This membership plan is not an insurance policy

Acknowledgment

All information included in the completed application is correct to the best of my knowledge, including all health insurance information. If your healthcare insurance is no longer in effect at the time air medical services are rendered, your PHI Cares Membership will not cover your air medical transport charges, unless you have notified PHI Cares of such cancelation and have paid the supplemental membership fee charged to PHI Cares members who do not have healthcare insurance. Any changes in your healthcare insurance information, including the cancelation of healthcare insurance coverage, must be reported to the PHI Cares Membership office within five (5) business days of such change or cancelation.

*In addition to PHI Air Medical, PHI proudly honors: StatFlight (Indiana), Air Evac Services (Arizona), Wellmont One (TN), LifeFlight of Michigan (MI), Baylor/Scott and White (TX) and The University of Maryland (MD) air ambulance providers.

Please be aware that your membership only covers out of pocket costs if transported by a PHI Air Medical program or its branded partners as stated above.

By approving this application for Membership, I agree to all conditions of PHI Air Medical Membership Plan Coverage Agreement as stated in said contract.

Signature: _____ Date: _____

Mail To: PHI Cares P.O. Box 731886 Dallas, TX 75373 - 1886
