# EMSAcare Member Application (West)

**YOU DO NOT NEED TO APPLY If you are an EMSAcare member through your city utility bill.**

| | |
|---|---|
| **ARE YOU AN EMSAcare MEMBER?** ☐ YES ☐ NO | |
| **NAME** LAST/ FIRST/ MIDDLE INITIAL: | EMAIL: |
| SOCIAL SECURITY NUMBER: | |
| DATE OF BIRTH: GENDER: ☐ M ☐ F | |
| STREET ADDRESS: | **IS THIS ADDRESS A NURSING HOME** OR OTHER FACILITY?: ☐ YES ☐ NO |
| CITY/ STATE/ ZIP: | **NAME OF FACILITY:** |
| HOME PHONE (10 DIGIT): | WORK PHONE (10 DIGIT): CELL PHONE (10 DIGIT): |

## Applicant Insurance Information

| | |
|---|---|
| DO YOU HAVE **MEDICARE PART B** ☐ YES ☐ NO | MEDICARE ID NUMBER: |
| DO YOU HAVE **MEDICAID** ☐ YES ☐ NO | MEDICAID NUMBER: |
| DO YOU HAVE **HEALTH INSURANCE** ☐ YES ☐ NO | INSURANCE COMPANY: |
| **INSURANCE COMPANY** STREET ADDRESS: | **INSURANCE COMPANY** CITY/ STATE/ ZIP: |
| IS THIS INSURANCE PROVIDED BY YOUR SPOUSE? ☐ YES ☐ NO | **POLICY/ ID NUMBER:** |
| INSUREDS EMPLOYER: | GROUP NUMBER: |

## Spouse Information

| | | | |
|---|---|---|---|
| **SPOUSE NAME** LAST/ FIRST/ MIDDLE INITIAL: | | | SOCIAL SECURITY NUMBER: |
| DATE OF BIRTH: | GENDER: ☐ M ☐ F | **DO THEY LIVE IN A NURSING HOME** OR OTHER FACILITY?: ☐ YES ☐ NO | **NAME OF FACILITY**: |
| DO THEY HAVE **MEDICARE PART B**? ☐ YES ☐ NO | | MEDICARE ID NUMBER: | |
| DO THEY HAVE **MEDICAID**? ☐ YES ☐ NO | | MEDICAID NUMBER: | |
| DO THEY HAVE **HEALTH INSURANCE**? ☐ YES ☐ NO | | **INSURANCE COMPANY** STREET ADDRESS: | |
| **INSURANCE COMPANY**: | | **INSURANCE COMPANY** CITY/ STATE/ ZIP: | |
| IS THIS INSURANCE PROVIDED BY YOUR SPOUSE? ☐ YES ☐ NO | | **POLICY/ ID NUMBER:** | |
| EMPLOYER: | | GROUP NUMBER: | |

## Permanent Residents of Household

**Please attach a separate sheet listing the names, dates of birth, social security numbers and insurance information for all other permanent residents of your household. See Who is Covered in the Membership Description and Agreement to determine eligibility.**

*I authorize any holder of medical information or documentation about me or any person covered under my EMSAcare membership to release to the Emergency Medical Services Authority (EMSA) and the Centers for Medicare and Medicaid Services and its agents and carriers any information or documentation needed to determine benefits payable for services provided to a covered person by EMSA in the past, now or in the future. I hereby assign to EMSA all my rights and benefits for ambulance services provided by any and all of my insurers and any third-party agencies. I further authorize my insurers and any third-party agencies to pay directly to EMSA whatever benefits or payments may be available for services rendered to me or permanent residents of my household by EMSA.*

*I agree to provide EMSA all information necessary to file a claim for payment under my insurance policy, plan or program or from my third-party payor.*

*Membership contract must be signed by the insurance policy holder. Membership is non-transferable and non-refundable and may be canceled upon member's non-compliance herewith.*

**SIGNATURE:** _____ **DATE:** _____

**DO NOT TEAR HERE,** *FOR OFFICE USE ONLY.*

## Method of Payment

(CIRCLE ONE) PERSONAL CHECK MASTERCARD VISA DISCOVER

CARD NUMBER: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ CARD EXPIRES _____

NAME OF CARDHOLDER _____

If cardholder billing address varies from member address, please indicate billing address on a separate sheet.

**PLEASE READ THE AGREEMENT, COMPLETE YOUR APPLICATION AND SEND, ALONG WITH PAYMENT, TO: EMSAcare WEST - PO Box 843979 Kansas City, MO 64184-3979**

**MEMBERSHIP: $45**

Form Revised 8/1/2024
Brochure Revised 8/1/2025