

How to Enroll

Complete the EMS Prepay Application (please print or type). Mail the completed application and your check or money order in the amount of \$50.00 to:

**New Kent Fire-Rescue
EMS Prepay Program
P.O. Box 8488
Virginia Beach, Va. 23450**

After your application is processed, your canceled check will serve as your receipt confirming your enrollment in the subscription program.

**For assistance with billing questions, please call
Diversified Ambulance
Billing, Inc.,
(800) 355-1753**

Questions about billing?

contact

Diversified Ambulance Billing, Inc.

(800) 355-1753



For questions concerning the prepay program itself, please contact New Kent Fire-Rescue at:

P.O. Box 69

Providence Forge, Va. 23140

(804) 966-9618



www.nkfr.net

EMS PREPAY APPLICATION



EMS Prepay Application Form

The **EMS Prepay Program** is a subscription program to help citizens defray out-of-pocket expenses, such as health insurance co-payments and deductibles, when they need emergency ambulance transportation. On July 1, 2007 New Kent Fire-Rescue Emergency Medical Services will begin billing for emergency ambulance transportation as part of the County's EMS Cost Recovery Program. Subscribers will not be charged for any cost not covered by their insurance company. Potential subscribers should check with their health insurance carrier to determine if the **EMS Prepay Program** is right for them.

For \$50.00 a year, a subscriber may enroll all members of his or her household. A subscription covers individuals listed on the application form, who reside at the listed address. A residential subscription also includes family members of the subscriber listed on the application, who reside in assisted-living or nursing facilities located within New Kent County.

Part 1 Applicant

Last Name	First Name	Middle	Social Security Number	Date of Birth

Street Address

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City	State	Zip	Telephone Number

Is this a renewal? Yes No

Part 2— Additional Residents at this address:

Last Name	First Name	Middle	Social Security Number	Date of Birth

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to New Kent Fire-Rescue (NKFR) or its billing agent for any services provided to me by NKFR. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services or its successors and its carriers and agents, as well as to NKFR and its billing agents, any information or documentation needed to determine these benefits, or benefits payable for any services provided to me by NKFR, now or in the future. I agree to immediately remit to NKFR any payments that I receive directly from any source for the services provided to me. A copy of this form is as valid as the original.

Signature _____ Date: _____