

Gilbertsville Area Community Ambulance Service



Subscriber Invitation

You are invited to take this opportunity to become a Gilbertsville Area Community Ambulance Service ("GACAS") subscriber. The membership is offered as *additional* insurance for you or for your family. Even though insurance may cover a portion of your cost for ambulance services, in most cases it will not cover the full amount. Your GACAS membership will offer you the additional coverage so **you are not responsible for any unpaid ambulance costs.**

GACAS will bill a non-member insurance company. Non-member patient will be responsible to pay 100% of the remaining ambulance costs after the insurance payment.

STAFF

GACAS staff includes Paramedics and Emergency Medical Technicians twenty-four (24) hours, every day of the year.

If you have any questions or are interested in joining GACAS as a Paramedic or Emergency Medical Technician, please call 610.367.9191 or e-mail gacas332@gmail.com or go to www.medic332.org

THIRD PARTY BILLING

Third party billing is a program that provides reimbursement for medical services. For GACAS, the compensation is based on rendered services. The charges could be for treatment at the scene with no transporting or at the scene services with transportation to a medical facility. Insurance companies and government programs (i.e., Medicare and Medicaid) will usually reimburse only a portion of the ambulance charges.

As a GACAS subscriber, when you or a family member requires Emergency Medical Service, GACAS will bill your insurance company and you need to do nothing more.

If a subscriber receives an insurance check for related GACAS ambulance services, that payment, along with a copy of the explanation of benefits, should be forwarded to GACAS immediately. Failure to do so may constitute insurance fraud on behalf of the subscriber.

As a GACAS subscriber, if your insurance company denies the claim you will not be billed for any unpaid ambulance charges.

Gilbertsville Area Community Ambulance Service (GACAS) is a non-profit organization serving Douglass-Montgomery and New Hanover Townships for over 30 years. GACAS has provided fast and efficient 24 hour, year around, emergency care through a highly medically trained and courteous team, always the leader in the latest life saving techniques and equipment.

Patients often compliment staff members on the courtesy, respect and dignity they are shown.

GACAS SERVICES IN 2012

- Responded to over 1500 ambulance calls
- Provided stand-by coverage for fire calls, search and rescue operations, school and community events
- Offered continuing education classes for Medical Personnel and Fire Fighters
- Free First Aid and CPR training for the public

GACAS exceeds all state licensure requirements and provides professional patient care and transportation to all hospitals in the area.

GACAS wants to continue to provide you the best possible emergency care now and in the future. To do this, YOUR HELP IS NEEDED.

In spite of increasing costs, GACAS membership remains the same. GACAS receives contributions from Boyertown Area United Way and municipalities. These donations do not cover all of the financial needs to fund the operation of the organization.

Thank you for your continued support of the yearly membership subscription program. Only through your support can GACAS provide you and your family members with the best possible emergency medical service available.

- **If you have been a member in the past, GACAS asks for your continued support.**
- **If you have not subscribed to a GACAS membership, please join because your support is needed!**

To subscribe, completely fill out both sides of the enclosed subscription card. Mail it in the enclosed envelope with your check made payable to Gilbertsville Area Community Ambulance Service. Please make sure all eligible family members are listed on the back of the card and that the mailing address is correct.

Please Explore GACAS website links:

www.medic332.org

www.douglasstownship.org

www.newhanover-pa.org

Dial 9-1-1

Tell the dispatcher:

1. Where you are, including any special landmarks.
2. What happened.
3. Your name.
4. Your telephone number.
5. Any other information requested.
6. If possible have someone wait outside for the ambulance.



“GACAS Appreciates Your Continued Support for over 30 Years.”



what matters.®

GILBERTSVILLE AREA COMMUNITY AMBULANCE SERVICE

2014 - 2015

ANNUAL SUBSCRIPTION REQUEST

2014 - 2015

MAKE CHECK PAYABLE TO:
GILBERTSVILLE AREA COMM.
AMBULANCE SERVICE
PO BOX 332, 91 JACKSON RD
GILBERTSVILLE PA 17525

INFORMATION CALLS ONLY:
610-367-9191

ALL EMERGENCY CALLS:
DIAL 9-1-1

SUBSCRIBER NAME:

SUBSCRIBER NO.:

INDIVIDUAL	FAMILY	ADDITIONAL	DONATION
\$70.00	\$70.00	DONATION	TOTAL
		\$	\$

TEAR ALONG THIS EDGE

PLEASE COMPLETE THE INFORMATION ON BACK SIDE OF THIS FORM.

PLEASE REFER TO YOUR SUBSCRIBER
NUMBER ON ALL CORRESPONDENCE.

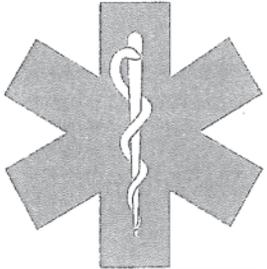
PLEASE
CORRECT
NAME
AND
ADDRESS

2014 - 2015 SUBSCRIPTION REQUEST

EXPIRES JUNE 30, 2015

RETAIN THIS PORTION

**RETAIN THIS STUB FOR
YOUR RECORDS**



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Amount Paid Date Paid

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Check Number

AUTHORIZATION

I authorize that payment of authorized Medicare Benefits or other insurance benefits be made on my behalf for any service furnished by this health service provider or supplier. I authorize any holder of medical information or documentation about me to release to the Health Care Financing Administration and its carrier and agents, as well as this health service provider, an information or documentation needed to determine these benefits or benefits payable for any services provided to me by this health service provider now or in the future. I understand that I am financially responsible for the services provided to me or my family members by this health service provider or supplier regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the health service provider or supplier or its billing agent for any services provided to me by the health provider or supplier. I authorize and direct any holder of medical information or documentation about me to release to the Center for Medicare and Medicaid Services and its carriers and agents, as well as to this health provider or supplier and their billing agents, any information or documentation needed to determine these benefit payable for any services provided to me by the health service provider, both now or in the future. A copy of this form is as valid as the original. I also agree to immediately remit to this health service provider any payments that I receive directly from any source for the services provided to me, now or in the future.

Signature _____ Date _____

List Family Members To Be Covered

NAME	DATE OF BIRTH	RELATIONSHIP