WEST YORK AMBULANCE, INC.

SUBSCRIPTION RATES
Based on singles or families
Regular: (18 years to 64 years old) - $40.00
Children over 18 living at home require their own membership
Seniors: (65 and above) - $25.00 (husband & wife)

Subscription Rate: _____

Donation (Optional): _____

Total Enclosed: _____

With each $100 donation your name will be noted on a plaque at West York Ambulance.

Please make necessary corrections to name and address below

Please complete the back of this form

This subscription entitles holder unlimited Emergency Medical Service, and additional ancillary services, until February 28, 2022, subject to terms and conditions which are available upon request.

West York Ambulance, Inc. reserves the right to all available third party claims.

For additional information phone (717) 792-1610 between 8:00am – 4:00pm Monday – Friday. **FOR EMERGENCIES DIAL 911**

Thank You For Your Support

Subscription Form

Make check Payable to:
West York Ambulance, Inc.
320 East Berlin Road
York, PA 17408

*For any **questions**, please call 792-1610*

Subscription Card

West York Ambulance, Inc.
320 East Berlin Road
York, PA 17408

Valid March 1, 2021 – February 28, 2022

Emergencies Dial: 911

SIGN AND RETURN COMPLETED CARD WITH PAYMENT

Please list all family members residing in your home. Please print all names.
CHILDREN OVER THE AGE OF 18 REQUIRE THEIR OWN SUBSCRIPTION

	AGE		AGE
_____		_____	
_____		_____	
_____		_____	
_____		_____	

I authorize the payment of authorized Medicare Benefits or other insurance benefits be made on my behalf for any services furnished by the 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 any information or documentation needed to determine these benefits or benefits payable for any services provided to me by the health service provider now or in the future. I understand that I am financially responsible for the services provided to me or any 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. I authorize and direct any holder or 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 benefits payable for any service 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: _____
HEAD OF HOUSEHOLD