



SOUTHEAST EMERGENCY MEDICAL SERVICE INC.



THERE WHEN YOU NEED US
SEEMS LIKE THE RIGHT CHOICE

Dr. Tim Simon—Medical Director

MEMBERSHIP INFORMATION

*SOUTHEAST EMS INC.
503 WEST GAINES/PO BOX 714
MONTICELLO, AR 71655
PHONE: 870-367-2300
FAX: 870-367-5062*

We are owned and operated in Monticello/Drew Co. *Dedicated to the preservation of life in our community*
SouthEast Emergency Medical Services, Inc. is dedicated to providing quality care for our citizens. We continuously strive to bring to our community a pre-hospital care program that Monticello/Drew County can be proud of.

At SouthEast EMS we provide Advance Life Support in all our ambulances. Our Advance Life Support units provide EKG testing. Our Advance Life Support units carry well beyond the minimal standard amount of equipment and supplies to provide you with the care that you or your family may need.

Our Protocols afford us the latitude to make the life saving decisions and treatment that is important to you and your family. Our dedication and commitment to providing Quality care to our patient's has earned us the respect of the physicians at Drew Memorial Hospital. They have supported our endeavors from the beginning, in making advancements to pre-hospital care in Monticello and Drew County.

PLEASE NOTE: Membership programs may not be beneficial to Medicaid recipients and nursing home patients, or if you have Medicare and a supplement (s). We encourage you to check your health insurance policies before making a decision about a membership. If you should have any questions regarding memberships for ambulance services, please feel free to call, or stop by our office. We will be glad to answer your questions.



Remember: An Ambulance membership is not an insurance policy,, nor is it an insurance supplement. I understand that by becoming a member of SouthEast EMS Inc. I am responsible for paying any balance due that may exist after my insurance has paid and my bill has been reduced by 40% from the original amount incurred. I further understand that all ambulance services are to be a medical necessity. (if you should have any uncertainty of medical necessity, please contact the ambulance service for help) I further understand the ambulance service will transport to the nearest appropriate hospital for evaluation, treatment and stabilization prior to being transferred to another hospital. I further understand that in a life threatening situation I will be taken to the nearest facility for treatment to save mine or my families life.

SOUTHEAST EMERGENCY MEDICAL SERVICE INC.

**MEMBERSHIP APPLICATION
(This is not an insurance policy)**

Date: _____

Individual \$29.00
Family \$39.00

Your name: _____

SSN# _____

Spouse: _____

SSN# _____

Your Date of Birth: _____

Spouse's Date of Birth: _____

Your Medicare# _____

Your Medicaid# _____

Spouse's Medicare# _____

Spouse's Medicaid# _____

Other Insurance _____

Mailing Address _____ **Phone** _____

Children under 18 or full time student _____

I acknowledge that I am responsible for payment of service. Membership coverage is limited to transports covered by insurance. I request that payment or authorized Medicare benefits be made on my behalf to SouthEast Emergency Medical Services, Inc. for any ambulance services provided to me.

I authorize any holder of medical information of documentation about me to release to the Health Care Financing Administration and its agents, as well as to SouthEast EMS, any information or documents needed to determine these benefits or benefits payable for related services provided to me by SEEMS now or in the future.



Recipients of Medicaid should not purchase a SEEMS membership, as beneficiaries are entitled to receive covered ambulance services at no direct cost. However, a SEEMS membership is available to help cover the cost of ambulance services not covered by Medicaid.

Application must be signed by all persons to be covered. All signatures will be kept on file.

Signature: _____ **DOB** _____ **SSN** _____

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