



PORTLAND AMBULANCE EMERGENCY CARE PLAN

Welcome! At Portland Ambulance, we are committed to providing you with the best care possible. Whether you're a returning subscriber or joining us for the first time, thank you for being part of the program. Patient care remains our top priority.

The annual membership fee is \$75. Please review the agreement on the following page carefully before signing. Applications, along with copies of your insurance cards and payment, must be submitted by the enrollment deadline of July 1, 2026. This applies to both new and renewing members.

If you have questions or need additional information, please call the Ambulance Director at (517) 647-2935.

FREQUENTLY ASKED QUESTIONS

Who can subscribe?

Any household residing in the coverage area of Portland Ambulance Service, regardless of financial status or insurance coverage. **NOTE: A household is considered all persons claimed on enrolling member's Federal Tax Return for the previous year (2025). Any exception must have approval from the Ambulance Director prior to entering into this agreement.*

How do I enroll in the Plan?

Carefully read the agreement on the following page and fill it out completely. **You may enroll anytime between May 1 and June 30, 2026.** Your enrollment covers medically necessary service from July 1, 2026, through June 30, 2027.

Submit your form with payment and copies of your insurance cards to:
City of Portland, Attn: Emergency Care Plan, 259 Kent St, Portland, MI 48875.

What does the Plan cover?

The plan covers all medically necessary ambulance runs during the coverage year of July 1, 2026, through June 30, 2027.

Do I have to renew every year?

Yes. With changes in insurance billing requirements, we must renew your signature and verify your insurance cards every year. This ensures correct and efficient billing to your insurance company.

Does the Plan cover services by other ambulance companies?

No. At times, Portland Ambulance is busy assisting other patients and may not have an ambulance available; the next closest ambulance service may respond to your emergency. You may want to consider participating in additional care plans offered by neighboring ambulance services if this concerns you.

2026-2027 | PORTLAND AMBULANCE EMERGENCY CARE PLAN Membership Application & Agreement Form

HEAD OF HOUSEHOLD INFORMATION:

Name: _____ Date of Birth: _____
Address: _____ City/State/ZIP: _____
Township/Village: _____ Phone Number: _____
Employer: _____ Renewal? Yes No

Other Eligible* Household Members:

1. Name: _____ Date of Birth: _____
2. Name: _____ Date of Birth: _____
3. Name: _____ Date of Birth: _____
4. Name: _____ Date of Birth: _____

INSURANCE INFORMATION:

Head of Household _____ *Spouse (if applicable)* _____
Medicare #: _____ Medicare #: _____
Medicare #: _____ Medicare #: _____

PLEASE SUBMIT WITH A COPY OF ALL CURRENT INSURANCE CARDS (RENEWALS INCLUDED)

Commercial Insurance Company: _____

Name of Insured: _____
Policy Number: _____ Group Number: _____

Commercial Insurance Company #2: _____

Name of Insured: _____
Policy Number: _____ Group Number: _____

Please read the following agreement and sign below. Payment must accompany the form for the agreement to be valid.

I understand that the **\$75 annual membership fee** limits my out-of-pocket expenses for the uninsured portion of ambulance bills for **medically necessary** transportation provided only by Portland Ambulance. I understand that the Emergency Care Plan is not an insurance program, and that Portland Ambulance will bill all applicable insurance plans, including supplemental and complementary coverage, and will accept any payments received as full payment. ***I further understand that ambulance transport that is not a medical emergency is not covered and becomes my responsibility.*** I understand that my signature below authorizes Portland Ambulance to bill all insurance carriers on my behalf and allows those carriers to make payments directly to Portland Ambulance. If I receive payment from my insurance for any services provided, I agree to immediately forward it to *MHR, PO Box 13247, Lansing, MI 48901-3247*. My signature also authorizes the release of ambulance-related information to my insurance for billing purposes. **Membership fees will be collected from May 1 through June 30, 2026. Coverage runs from July 1, 2026, through June 30, 2027.** Membership is non-transferable and non-refundable.

I have read and agree with the above statements.

Head of Household Signature: _____ Date: _____

Spouse Signature: _____ Date: _____