



## PLYMOUTH COMMUNITY AMBULANCE ASSOCIATION



This subscription entitles holder unlimited Emergency Medical Service until April 30, 2026, subject to terms and conditions which are available upon request.

Plymouth Community Ambulance Association reserves the right to all available third party claims.

**For additional information call  
610-277-2776 x1**

**Thank You For Your Support**

### Sign and Return This Completed Form with Payment

Please list all family members residing in your home. Please print all names.

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Telephone Number: (   ) - \_\_\_\_ - \_\_\_\_

#### Authorization

I understand that I am financially responsible for the services provided to me by Plymouth Community Ambulance Association, referred to as "PCAA" regardless of my insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to PCAA or its billing agent for any services provided to me by the Centers for Medicare and Medicaid Services and its carriers and agents, as well as PCAA and its billing agents, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by PCAA, both now or in the future. A copy of this form is as valid as the original. I also agree to immediately remit to PCAA any payments that I receive directly from any source for the services provided to me. If indicated on the reverse side, I authorize Plymouth Community Ambulance Association to charge the total amount of my subscription payment to my credit card account. I agree to the terms and conditions of the subscriber program described above. I verify that I am not a Medicaid recipient. By signing below, I acknowledge that I have read, understand and agree to the terms and conditions of the subscription program, and I hereby apply to be a subscriber of PCAA.

Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Head of Household or Credit Card Holder (If Applicable)