

Prism Emergency Medical Services MEMBERSHIP FORM

MEMBERSHIP RATES

Family: \$55 Individual: \$35

Subscription Rate: _____

Donation (optional): _____

Total Enclosed: _____

Please charge my credit card:

Visa Mastercard

Card Number: _____

Expiration Date: _____

Name on Card: _____

Signature: _____

Please make necessary corrections to name and address below.



Make check payable to:

Prism Health Services

4821 Buttermilk Hollow Road

West Mifflin, PA 15122

For any questions, please call 412-466-5111

PRISM HEALTH SERVICES INC.

Emergency Medical Services



Emergency Calls: 9-1-1

All Other Calls: 412-466-5111

Retain this card. Expires June 30, 2010

MEMBERSHIP CARD

REVERSE SIDE MUST BE COMPLETED TO ACTIVATE MEMBERSHIP

PRISM HEALTH SERVICES
EMERGENCY MEDICAL SERVICES



SIGN AND RETURN THIS COMPLETED FORM WITH PAYMENT

Please list all family members residing in your home. PLEASE PRINT ALL NAMES.

Telephone Number: _____

AUTHORIZATION

I request that payment of any authorized insurance benefits be made on my behalf to Prism Health Services Inc., E.M.S. for any ambulance services provided to me by Prism Health Services Inc. I authorize 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 Prism Health Services Inc., E.M.S., any information or documentation needed to determine these benefits payable for any services provided to me by Prism Health Services Inc.

For additional information call 8AM-4PM Mon.-Fri.
412-466-5111

THANK YOU FOR YOUR SUPPORT

Signature X _____

Head of Household