



POINT PLEASANT - PLUMSTEADVILLE

Emergency Medical Services

2026 Subscription Rates:

<input type="checkbox"/> Single Rate.....	\$65.00
<input type="checkbox"/> Family Membership Rate	\$110.00
<input type="checkbox"/> Senior Individual Rate (62 & Over).....	\$40.00
<input type="checkbox"/> Additional Tax-Deductible Donation.....	\$_____
Total Amount Enclosed	\$_____

For payments via PayPal, please include your membership type along with your reference number and address.

Reference No.

Visit our secure website to use:



www.medic124.org



Please make necessary corrections to name and address.

PLEASE COMPLETE AND RETURN THIS PORTION.

SUBSCRIPTION FORM

Please make checks payable to:

Point Pleasant - Plumsteadville EMS or PPPEMS

and mail to:

P.O. Box 391

Plumsteadville, PA 18949

Info: (215) 766-7285 • Billing: (877) 214-6018

Reference No.

2026

POINT PLEASANT PLUMSTEADVILLE

Emergency Medical Services

Name: _____

\$ _____
AMOUNT

Thank you for your tax free contribution!
EMERGENCIES: DIAL 9-1-1

Valid: January 1st, 2026 - December 31st, 2026

KEEP THIS PORTION

POINT PLEASANT PLUMSTEADVILLE

Emergency Medical Services



PLEASE NOTE: Any and all monies received by the subscriber from their insurance company for services provided by Point Pleasant - Plumsteadville EMS, must be paid to Point Pleasant - Plumsteadville EMS. Failure to do so will result in the immediate termination of any subscription agreement and you will be held responsible for payment of all outstanding balances.

For additional information, call

(215) 766-7285

Thank You For Your Support.

AUTHORIZATION

I authorize the payment of authorized Medicare Benefits or other insurance benefits be made on my behalf for any services furnished by this health service provider or supplier. I authorize any holder of medical information or documentation about me to release to the Healthcare Financing Administration and its carrier 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 this health service provider now or in the future. I understand that I am financially responsible for the services provided to me or my 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 or its billing agent for any services provided to me by the health provider or supplier. I authorize and direct any holder of medical information or documentation about me to release to the Center of Medicare and Medicaid Services and its carriers and agents, as well as to this health provider or supplier and their billing agents, any information on documentation needed to determine these benefits payable for any services provided to me by the health service provider, both now and 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: _____ Phone #: _____ Date: _____ E-mail: _____

**PLEASE LIST ALL FAMILY MEMBERS RESIDING AT THIS ADDRESS
TO BE COVERED BY THIS MEMBERSHIP.**