SUNSTAR FirstCare Ambulance Membership Application and Agreement - 2026

Member Information		
Primary Member #1 Full Name and Address:	**Social Security #:**	**Birth Date:**
	Email Address:	
#1 REQUIRED Signature:	**Date Signed:**	**Phone #:**

Insurance Information		
Primary Insurance:	**ID #:**	**Group #:**
Secondary Insurance:	**ID #:**	**Group #:**

Additional Family Members		
Family Member #2 Name:	**Social Security #:**	**Birth Date:**
Insurance:	**ID #:**	**Group #:**
#2 Signature (If Applicable):	**Date Signed:**	**Phone #:**
Family Member #3 Name:	**Social Security #:**	**Birth Date:**
Insurance:	**ID #:**	**Group #:**
#3 Signature (If Applicable):	**Date Signed:**	**Phone #:**
Family Member #4 Name:	**Social Security #:**	**Birth Date:**
Insurance:	**ID #:**	**Group #:**
#4 Signature (If Applicable):	**Date Signed:**	**Phone #:**

Use a separate piece of paper to add additional family members and/or additional insurance information

Payment Information

FOR YOUR SECURITY, CREDIT CARD PAYMENTS ARE NO LONGER ACCEPTED BY MAIL.
To pay by credit card, please submit a completed application and a representative will contact you to process the transaction by phone, or you can pay online at https://pay.bill2pay.com/client/PdocNLSEMS
For online payments via Bill2Pay indicate "Membership" in the Run # field and note the confirmation # below.
CREDIT CARD CONVENIENCE FEE: **$2.50 for a single plan and $5.00 for a family plan**

Please check one:	☐ **$133.00 Family**	☐ **$89.00 Single**
☐ ****Credit Card**	☐ **Check/Money Order #:**	☐ **Paid Online – Ref #:**
How did you hear about FirstCare?		

RETURN THIS FORM WITH CHECK OR MONEY ORDER TO SUNSTAR: P.O. Box 31074, Tampa, FL 33631-3074
For more information, please visit our website at: https://pinellas.gov/firstcare Or contact our office at (727) 582-2008.
Please read the FirstCare Membership Agreement prior to signing.
The application **MUST BE SIGNED** by all members 18 years of age and over.

SUNSTAR FirstCare Ambulance Membership Application and Agreement - 2026

ENROLLMENT FEE: I understand that the Membership fee for Sunstar FirstCare limits my out-of-pocket expense for the uninsured portion of Sunstar ambulance bill(s) for medically necessary ambulance transportation. I acknowledge that I am responsible for the payment of ambulance services provided to me by Sunstar and my Membership fee for the Sunstar FirstCare Ambulance Membership covers my copayments and deductibles. If my claim is denied by my active insurance, the Membership may cover 50% of my ambulance bill if certifying documentation is provided indicating the transport was medically necessary. **If I DO NOT have active insurance, including Medicare or Medicaid**, the Membership may cover **20%** of my ambulance bill if the transportation was medically necessary. Annual Membership fees: Single Membership is **$89**; Family Membership is **$133**. Please make check or money order payable to Sunstar and mail check with your completed application to: Sunstar at P.O. Box 31074, Tampa, FL 33631-3074. **ALL payments made by credit card will be charged a convenience fee of $2.50 for each increment of $100 paid. The credit card convenience fee is $5.00 for a Family plan and $2.50 for a Single plan.**

WHAT IS MEDICALLY NECESSARY AMBULANCE TRANSPORTATION? Medically Necessary means there must be a specific medical need for an ambulance, to or from a medical facility for medical treatment using Medicare standards. Sunstar requires a physician certification or supporting documentation from your treating medical doctor when a transport is denied for medical necessity, to indicate why your condition necessitated an ambulance. If the physician certification is not received **within 60 days from the date of the insurance denial**, the member may receive a bill for the full cost of the ambulance transport.

MEMBERSHIP COVERAGE: The Membership covers medically necessary ambulance transports within the Pinellas County "locality" by Sunstar ambulance units only. "Medicare definition of "Locality": "*with respect to ambulance service means the service area surrounding the institution to which individuals normally travel to receive hospital or skilled nursing services"*. The Membership does not cover transports via Sunstar's Mental Health Transport Van.

COMPLIANCE WITH SECTION 119.071 (5), FLORIDA STATUTES REGARDING COLLECTION AND USAGE OF YOUR SOCIAL SECURITY NUMBER: Pursuant to requirements outlined in Florida Statutes Section 119.071 (5), OTHER PERSONAL INFORMATION, we are hereby advising you that the collection of your social security number is imperative for the performance of the billing and insurance verification processes. Your Social Security Number will be used for billing purposes and to enable other healthcare providers and/or insurers to identify your applicable records.

ELIGIBLE FAMILY MEMBERS: The Family Membership covers family members related by blood, adoption, marriage, or registered domestic partnership who permanently reside in the same household as the primary member.

ASSIGNMENT OF INSURANCE BENEFITS: I acknowledge that I am responsible for paying ambulance services provided to me by Sunstar, except those eligible under the Membership. I acknowledge that Sunstar will file claims on my behalf with my primary and secondary (if applicable) insurance carrier(s) including Medicare. I herein assign my right to reimbursement for covered transports to Sunstar.

INSURANCE PAYMENT OF CLAIMS: I authorize payment resulting from claims billed on my behalf be made directly to Sunstar. In the event I receive payment directly from my insurance company related to the transport, I agree to endorse the check, include the Explanation of Benefits (EOB), and mail to: Sunstar at P.O. Box 31074, Tampa, FL 33631-3074. If I do not forward the payment to Sunstar, I understand I will receive a bill and be responsible for the payment of this amount.

RELEASE OF MEDICAL INFORMATION: As a part of the billing process, I authorize release of any holder of medical information about me or other relevant documentation about me to release to the Centers for Medicare and Medicaid Services and its agents and contractors, any and all appropriate third party payers and their respective agents and contracts, as well as Sunstar, any information or documentation in their possession needed to determine these benefits and/or the benefits payable for related service, whether in the past, now or in the future.

EFFECTIVE DATES: **NEW MEMBERSHIPS:** Completed applications with payment in full, received prior to the end of the calendar year, will be effective on January 1st. Completed applications with payment in full received after January 1st, will be effective on the postmark date. **RENEWALS:** Completed applications with payment in full (received prior to April 1st) will be effective April 1st. All memberships expire on March 31st of the following year. **Members whose applications are received or postmarked after March 31st will not have FirstCare coverage until payment is received in full. Membership will be effective on the postmark date. Membership fees will not be pro-rated.**

REFUNDS: I acknowledge that Membership fees are non-refundable and are used to cover the cost of administering the Membership plan and processing my application. I am therefore not entitled to any refund of monies paid to Sunstar under this agreement after the agreement's effective date. Membership is not transferrable.

NEED FOR MEMBERSHIP COVERAGE: If I have medical insurance, I acknowledge that I have reviewed my coverage as it pertains to ambulance transportation and have made a voluntary determination to enroll in the Membership plan, as some insurance carriers cover 100% of ambulance transportation.

PROOF OF MEMBERSHIP: Your check or credit card statement is your receipt. Membership cards are unnecessary and are not issued. If you are transported, your Membership will be verified by Sunstar.

GROUNDS FOR TERMINATION: Misuse or misrepresentation of required documents could result in the termination of your Membership agreement and a non-refundable Membership fee.

BY SIGNING THE MEMBERSHIP APPLICATION & AGREEMENT, I AGREE TO ABIDE BY THE TERMS HEREOF.