

**NAZARETH  
AMBULANCE CORPS**  
PO BOX 326 • NAZARETH, PA 18064

Please Refer To This Number On Any Correspondence >

**2007-2008  
SUBSCRIPTION RECEIPT**

*Subscription Begins: May 1, 2007  
Expires: April 30, 2008*

**EMERGENCY PHONE: DIAL 911**  
INFORMATION: 610-759-5422

**MAKE CHECKS PAYABLE TO:  
NAZARETH AMBULANCE CORPS**

**Retain This Stub For Your Records**

**Check #** \_\_\_\_\_

**Date** \_\_\_\_\_

**Amount \$** \_\_\_\_\_

**Thank You For Your Tax-Deductable Contribution**

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**NAZARETH  
AMBULANCE CORPS**

*Check Amount of Subscription & Return This Portion In The Envelope Provided*



- Senior Family Subscription \$70.00
- Senior Individual Subscription \$50.00
- Family Subscription \$95.00
- Individual Subscription \$75.00
- Additional Donation \$\_\_\_\_.00

**TOTAL ENCLOSED.....** \$\_\_\_\_\_

**Make Checks Payable to: NAZARETH AMBULANCE CORPS**  
*Your contribution is Tax-Deductible*

NAZARETH AMBULANCE CORPS  
PO BOX 326  
NAZARETH PA 18064-0326



**2007-2008  
SUBSCRIPTION REQUEST**

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**SUBSCRIPTION ROSTER**

*Please list all members you intend to  
include on the Subscription.*

	Name	Age
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

**LIFETIME INSURANCE AND SIGNATURE  
AUTHORIZATION**

I authorize that payment of authorized Medicare benefits or other insurance benefits be made on our behalf to Nazareth Ambulance Corps for any ambulance or medical transportation services furnished to us by Nazareth Ambulance Corps, the Centers for Medicare and Medicaid Services, or its carriers and agents or any other applicable insurance companies, any information or documentation needed to determine these benefits or benefits payable for any services provided to us by Nazareth Ambulance Corps, both now and in the future. We agree to remit to Nazareth Ambulance Corps any payments that we receive directly from any source for services provided to us and assign all rights to such payments to Nazareth Ambulance Corps. We also authorize Nazareth Ambulance Corps and its billing agent to appeal any HMO claim on our behalf.

**X** \_\_\_\_\_  
Signature of Authorized Person

THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR PAYMENT.