crescentinsurance
SERVICES
4408 Forest Drive, Suite 202 • Columbia, SC 29206
Ph: (888)249.9002 • Fax: (803)782.0232

NASE

Ground Ambulance Service Benefit Claim Form

Member: _____

Address: _____

City, State, Zip Code: _____

Date: _____

Member # _____

Phone: (Home) _____**Business** _____

E-mail address: _____

Fax _____**Social Security #** _____

Cause of Loss (Describe Illness or Injury)

_____

_____

Date of Loss:

_____

Name of Ambulance Service:

_____

Was transportation to or from the hospital?

_____

Attending Physician/Medical Provider:

_____

Attach copy of invoice for ambulance service

Member Signature:_____ **Date:** _____

Requirements for Eligible Claim

Benefit/Limit: Up to $200.00 for emergency Ground Ambulance Service payable one time per policy year for one trip per policy year to or from a Hospital as the result of an accident or sickness.

Conditions: Ground Ambulance Service Benefit applies to the Gold membership category only.

Member must be in good standing at the time the service is provided.

Coverage extends only to transportation to or from a Hospital in the event of an emergency or illness.

Definitions:

Ground Ambulance Service: Ground Ambulance Service means physical transportation in an appropriate vehicle registered to a licensed medical transportation service.

Hospital: Hospital means any institution duly licensed, certified and operated as a hospital.

Directions for completing Loss Notice

Member:	Complete name as stated on your Membership
Address:	Complete address you can be contacted
Date:	Date you are completing the form
Member #:	Your membership number
Phone:	Home phone number with area code
E-mail address:	E-mail address if preferred
Business Phone:	Business phone number with area code
Fax:	Fax number with area code
SS#:	Social Security Number
Cause of Loss:	Describe the reason for the use of the ambulance
Attending Physician/Medical Provider:	Please provide the name and contact information of the attending physician and/or medical provider.

BE SURE TO INCLUDE A COPY OF THE INVOICE FROM THE AMBULANCE SERVICE

Sign and date the Claim Form and send completed form with attachments to:

Crescent Insurance Services
4408 Forest Drive, Suite 202
Columbia, SC 29206
Fax(803) 782-0232