



**Executive Medical Consultants (EMC)**  
**526 Canton Road, Suite 212, Akron, OH 44312**  
**Phone: 330-794-1200 / Fax: 330-315-2554**  
[www.EMCwins.com](http://www.EMCwins.com)

For Office Use Only Consultant Name _____ City _____ ID # _____
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**EMC Membership Agreement**

To enroll in your EMC Membership, please complete the information below. Upon receipt we can establish a record for you and begin analyzing your medical bills. Your information is kept private and confidential.

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Spouse Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Children's Names	Gender	DOB	Medical Care Provider (Insurance Company)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

*EMC educates its members on "what to do next" with your medical bills. It is important to understand that in our analysis of your medical bills, we may find that they are correct and true and must be paid. For these situations, we may also refer you to other community agencies that will help you defer payment of those costs, if possible.*

*Member's responsibility: You must call EMC for services and to get the answers to your questions.*

This is a one-year agreement for membership between Executive Medical Consultants (EMC) and the individual listed above. The beginning date is shown below.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Annual EMC Memberships are payable upon signing the EMC Membership Agreement. All memberships will be automatically renewed one year from the signing date. As a member you will receive an annual renewal notice, unless we have received a 30-day written notice of cancellation prior to the contract end date.

We provide two types of memberships – please choose:

- \$29 – Individual EMC Memberships are provided directly to one individual. (complete pages 1 & 2)
- \$39 – Family EMC Memberships include an individual and the members of his or her immediate family as follows: the member (complete pages 1 & 2), the member's spouse (complete page 3), and all unmarried dependent children, 18 or older who are covered on the member's insurance policy (complete page 3).

**After completing these forms, include a check for the membership selected, & mail to above address.**



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**EMC Membership Services Authorization**

When analyzing and resolving your medical bill issues, this request of information is used to provide EMC with authorization to speak to any agency that you use, or have used, in relation to your medical care provisions and payments. Please complete in full, sign and date. Thank you.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Insurance Co. Address: \_\_\_\_\_

Primary Member ID Number: \_\_\_\_\_ & Group Number: \_\_\_\_\_

2<sup>nd</sup> Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

2<sup>nd</sup> Insurer Member ID Number: \_\_\_\_\_ & Group Number: \_\_\_\_\_

3<sup>rd</sup> Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

3<sup>rd</sup> Insurer Member ID Number: \_\_\_\_\_ & Group Number: \_\_\_\_\_

EMC Associate Signature \_\_\_\_\_

**Disclosure Authorization for EMC Associates to represent this member:**

I, \_\_\_\_\_, hereby authorize EMC to speak to my insurance company and/or TPA, any credit collection agency, my physician, hospital, or any other medical provider or facility regarding resolution of my medical bills. This also allows EMC to help me clearly understand what needs to be done to arrange for my claims to adjudicate for payment according to my benefit plan.

Member Name (print): \_\_\_\_\_

Member Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Checkmark those that apply to you:  Veteran  Akron  Cleveland  Columbus  Florida  Arizona



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### EMC Membership Spousal Disclosure / Dependent Disclosure

When analyzing and resolving your medical bill issues, this request of information is used to provide EMC with authorization to speak to any agency that you use, or have used, in relation to your medical care provisions and payments. Please complete in full, sign and date. Thank you.

Check One:  Spousal Disclosure or  Dependent Disclosure

If disclosures for both Spouse and Dependents are needed, duplicate and use this form for each person.

Member's Name: \_\_\_\_\_

Member's Spouse (only): \_\_\_\_\_

Member's Dependent (only): \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Disclosure Authorization for EMC Associates to represent this member's spouse or other dependent:

I, \_\_\_\_\_, hereby authorize EMC to speak to my insurance company and/or TPA, any credit collection agency, my physician, hospital, or any other medical provider or facility regarding resolution of my medical bills. This also allows EMC to help me clearly understand what needs to be done to arrange for my claims to adjudicate for payment according to my benefit plan.

OR

\_\_\_\_\_  
Spouse's Name (print):

\_\_\_\_\_  
Dependent's Name (print):

\_\_\_\_\_  
Spouse's Signature:

\_\_\_\_\_  
Dependent's Signature:

Date: \_\_\_\_\_



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## **EMC MEDICAL BILL ASSURANCE PROGRAM**

### **Member Benefits Sheet**

- We provide Total Medical Bill Management, as follows:
- We analyze and calculate for correctness all medical bills you receive and send to us.
- We research any errors found with your medical bills.
- We advocate for you to resolve your medical bill errors with all medical providers.
- As needed, we speak in your behalf to your insurance company, hospital, doctor, pharmacy, pharmaceutical company, area assistance programs, and other program advocates to resolve any billing or procedural problems.
- We review all denied claims and administer appeals on your behalf.
- We refer you to any and all programs that will assist with difficult problems.
- We review your medical insurance plan coverage with you in plain language.
- We recommend the best way to financially work through medical situations and paperwork.
- Prior to any hospitalization, we can inform you about your insurance plan coverage.
- Our services create peace of mind for you, regarding your medical bills and the paperwork.
- We provide easy enrollment – Call, or logon and create a membership at [www.emcwins.com](http://www.emcwins.com)
- We provide Gift Certificates to give memberships to your family and friends in need.

**This is the only service of its kind and price!**  
**Annual memberships are \$29 for individuals and \$39 for families!**

**ENROLL TODAY ~ SAVE TOMORROW!**  
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