EMPLOYER/3rd PARTY Billing Application 2023

Mail to: DIME Medical
340 Main Street
Darlington, WI 53530
Fax to: (855) 574-5406
Phone: (608) 482-2005

Company/Payor Name: _____ Date:_____

Contact Name:_____ Phone:_____

Contact Email:_____

Address for mailing:_____

_____

Above name should be payor for employees listed below:

1	4
2	5
3	6

Or "See Attached List of names"

CHOOSE WHICH PARTS & % for which you are willing to pay for members:
0% --- 50% --- 100%. Remaining percentages to be assumed paid by member/employee.

Registration - ONE TIME fee $50 per member, $25 for 4 or more	**MEMBERSHIP** SUBSCRIPTION This is the major recurring fee	**Laboratory Listed under "Miscellaneous" on invoice**	**Prescriptions** NOT AVAILABLE at this time	**Other Charges (ex contracted heart monitor service)**
%	%	%	%	%

Discount PAYMENTS

Membership	12 months 5.0%	6 months 2.5%	3months 1.0%
Adult $55.00/month	$627.00	$321.75	$163.35
Child $27.50/month	$313.50	$160.88	$81.68
Family $165.00+ (1) /month	$1,881.00 + (1)	$965.25+ (1)	$490.05+ (1)

COST for FULL 12 MONTHS

Membership	12 months 5.0%	6 months 2.5%	3months 1.0%
Adult $660/yr	$627.00	$643.50	$653.40
Child $330/yr	$313.50	$321.76	$326.70
Family $1,980+ (1) /yr	$1,881.00+ (1)	$1,930.50+ (1)	$1,960.20+ (1)

version 12/5/2022

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(1) Family = 2 Adults + 2 - 4 legal children + $10.50 per additional child per month
Please CHOOSE A METHOD OF PAYING:

1. **AUTOMATIC *BANK DEDUCTION*** (REQUIRES VERIFICATION from bank statement)

Name of bank:_____

Account holder name:_____

Routing Number:_____

Bank Account Number: _____

I authorize the direct bank deduction from my bank account to pay the Membership Fee:

_____ Every Month, _____ Every 3 months, _____ Every 6 months, ____ Every year

On the ____ 1st, _____5th , ____10th, ____15th, ____ 20th, ____25th of the month

Signature: _____ Date:_____

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2. **AUTOMATIC *CREDIT CARD***
Name on Credit Card: _____

Credit Card Number: _____ CVC: _____

Expiration Date:_____

_____ Every Month, _____ Every 3 months, _____ Every 6 months, ____ Every year

On the ____ 1st, _____5th , ____10th, ____15th, ____ 20th, ____25th of the month

Signature: _____ Date:_____

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3. MANUALLY pay each payment period of membership fee and any charges:

____ Personal Check, _____ Manual Credit Card payment, ____ Cash

Every: ____ Month, ____ Every 3 months, ____ Every 6 months, ____ Every Year

Please send me a bill for the charges. Payment is due be BEFORE services period begins.

Signature: _____ Date:_____