# EMPLOYER/3rd PARTY Billing Application

**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 $52.50/month | $598.50 | $307.13 | $155.93 |
| Child $26.25/month | $299.25 | $153.56 | $77.96 |
| Family $157.50+ (1) /month | $1,795.50 + (1) | $921.38+ (1) | $467.78+ (1) |

**COST for FULL 12 MONTHS**

| Membership | 12 months 5.0% | 6 months 2.5% | 3months 1.0% |
|---|---|---|---|
| Adult $630/yr | $598.50 | $614.25 | $623.70 |
| Child $315/yr | $299.25 | $307.13 | $311.85 |
| Family $1,890+ (1) /yr | $1,795.50+ (1) | $1842.75+ (1) | $1,871.10+ (1) |

version 12/12/21

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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:_____