

**MADDY EMS FUND
PHYSICIAN/SURGEONS
REIMBURSEMENT**

**TRINITY COUNTY ~ PROGRAM ENROLLMENT FORM
CERTIFICATION FOR REIMBURSEMENT OF
UNCOMPENSATED EMERGENCY MEDICAL SERVICES**

**ENROLLMENT FORM MUST BE COMPLETED YEARLY
CERTIFICATION PERIOD: July 1, 2023 - June 30, 2024
For Service Dates for Calendar Year 2022 Only**

PHYSICIAN: _____
LAST FIRST MI
PHYSICIAN ADDRESS: _____
CITY: _____ ZIP CODE: _____ E-MAIL ADDRESS: _____
TELEPHONE NO: () _____ CONTACT PERSON: _____
PRIMARY SPECIALTY: _____ STATE LICENSE NUMBER: _____
PLEASE SEND THE APPLICABLE W-9

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:
GROUP NAME: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:
COMPANY NAME: _____
ADDRESS: _____ CITY: _____ ZIP CODE: _____
TELEPHONE NO: () _____ CONTACT PERSON: _____

HOSPITAL:
 **MOUNTAIN COMMUNITY MEDICAL SERVICES (TRINITY HOSPITAL)
60 EASTER AVENUE
WEAVERVILLE CA 96093**
BY CHECKING THE BOX, YOU ARE AFFERMING YOUR SERVICES AT THIS LOCATION IN THE EMERGENCY CARE FACILITY.

If the information provided changes in any way, a new program enrollment form must be submitted with the corrected/updated information. Each physician providing services under this program must complete this application.

I, _____, swear under penalty of perjury that the above information is true and correct to the best of my knowledge and understand the condition of claiming reimbursement under the Emergency Medical Services Fund Program.

SIGNATURE OF PHYSICIAN

DATE

NOTE: For prompt processing, submit this form as soon as possible to:
**TRINITY COUNTY AUDITOR-CONTROLLER'S OFFICE
PO BOX 1230
WEAVERVILLE CA 96093**
For questions please call: 530-623-8382 or email: cgaffney@trinitycounty.org