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, 2016 - June 30, 2017

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: 530-623-8283 or email: cgaffney@trinitycounty.org