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

ENROLLMENT FORM MUST BE COMPLETED YEARLY
CERTIFICATION PERIOD: July 1, 2021 - June 30, 2022
For Service Dates for Calendar Year 2020 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 AFFIRMING 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: cjohnson@trinitycounty.org