

MARYLAND TRAUMA PHYSICIAN SERVICES FUND

Reconciliation Report for Physician Uncompensated Care Payments

MARYLAND HEALTH CARE COMMISSION

Andrew N. Pollak, MD
Chair

Ben Steffen
Executive Director

HEALTH SERVICES COST REVIEW COMMISSION

Nelson J. Sabatini
Chair

Katie Wunderlich
Executive Director

Questions? CONTACT denise.ridgely@maryland.gov

You Must File

IF . . .

- You provide services to a trauma patient having no health insurance, including Medicare Part B coverage, VA health benefits, CHAMPUS, Worker's Compensation, and who is not eligible for Medical Assistance coverage., even if you received no subsequent payment.
- You received uncompensated care payments from the Fund and subsequently received a payment or payments from the patient, Medicare, Medicaid, the VA, Workmen's Compensation, CHAMPUS, a health insurance company, automobile insurance company, or an attorney as a result of a legal settlement.

Please remember...

If you receive a payment for a trauma patient that was previously reimbursed by the Fund, you must complete and remit this Reconciliation Report even if the payment is less than your practice's original billed amount.

1. Application Submission Date:

Month	Day	Year
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2. Practice Information:

Name of physician, practice, or center
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Street Address

City	State
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Zip Code	Area Code + Telephone Number
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E-mail Address

Tax ID number

3. Contact person if additional application information is needed:

Name	Title
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Street Address

City	State
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Zip Code	Area Code + Telephone Number
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E-mail Address

4. Trauma Center where care was provided:

5. During this reporting period, was money recovered from another payer source for past services declared and reimbursed by the Fund? Report the amount paid to you by other sources for which your practice had previously received Trauma Fund uncompensated care payments. \$ _____

**YOU MUST COMPLETE THE
PHYSICIAN, PATIENT, SERVICE & FINANCIAL INFORMATION
REQUESTED IN THE FOLLOWING TABLE IF THE AMOUNT
REPORTED IN QUESTION 5 IS GREATER THAN \$10.**

Please Note that the Definitions follow Table 1.

Definitions

Trauma Registry # --The patient's 8 to 9 digit number assigned by the trauma center's coordinator and reported on the Maryland Trauma Registry maintained by the Maryland Institute for Emergency Medical Services Systems.

Facility ID # -- Please use the following facility identification numbers to identify the trauma center.

Trauma Center	Facility ID #	Trauma Center	Facility ID #	Trauma Center	Facility ID #
Johns Hopkins Bayview Medical Center (Adult Trauma Center)	601	R. Adams Cowley Shock Trauma Center	634	Johns Hopkins Bayview Medical Center, Baltimore Regional burn Center	701
Johns Hopkins Hospital (Adult Trauma Center)	604	Suburban Hospital (Adult Trauma Center)	649	Johns Hopkins Wilmer Eye Institute	705
Peninsula Regional Medical Center (Adult Trauma Center)	608	Meritus Medical Center (Adult Trauma Center)	699	Johns Hopkins Hospital Pediatric Burn Unit	707
Sinai Hospital (Adult Trauma Center)	610	Johns Hopkins Medical Center (Pediatric Trauma Center)	704		
Western Maryland Regional Medical Center (Adult Trauma Center)	695	Children's National Medical Center (Pediatric Trauma Center)	717		
Prince George's Hospital Center (Adult Trauma Center)	632	Union Memorial Hospital Curtis National Hand Center	714		

Patient Last Name – The last name of the patient receiving trauma services.

Date of Service -- The date the patient arrived in the trauma center or date of follow-up care.

Total Payment Received from the Trauma Fund (Column A) – Amount of payment from the Fund

Amount Received from Other Source(s) (Column B) – The amount paid to the practice from other sources as identified below

Source of Additional Funds – Definitions (Column C):

1=Medicaid or Medicaid MCO

2=Medicare

3=VA Benefits

4=Champus

5=Workers' Compensation Health Benefits

6=Private Health Insurance, including Medicare Supplemental

7=Payment from Patient

Amount Returned to Trauma Fund (Column D) - Amount to be reimbursed to the Trauma Fund

(Add Column A, Minus Column, B equals Column D)

VERIFICATION

I hereby certify that the facts stated in this Maryland Trauma Fund Reconciliation Report are accurate and true to the best of my knowledge and that the faculty or physician practice followed and adhered to its established collection policies and procedures before submitting this claim for reimbursement by the Maryland Trauma Physician Services Fund.

(Name of Physician Practice or Group - please print or type)

(Physician Group Designee's Name & Title – please print or type)

(Physician Group Designee's Authorized Signature)

(Date)

**PLEASE RETURN THIS REPORT AND YOUR
REIMBURSEMENT TO:**

**Denise Ridgely
Program Manager
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215**

**MAKE THE CHECK PAYABLE TO:
State of Maryland, Maryland Trauma Physician Services Fund**

THANK YOU.