NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM

GENERAL INFORMATION

Any and all payments received by Contractor from a Trauma Patient or from third-party payers, including a legal settlement, for a claim previously submitted to and not rejected by the County, must be immediately reported to the County and the payment amount shall be surrendered and remitted to the County since Contractor assigned and subrogated its rights to said claim. Contractor must remit to the County the payment it received within sixty (60) days of receipt of such payment and must complete and submit a TRAUMA CENTER PAYMENT SURRENDER FORM with each surrendered payment.

COMPLETION OF THE TRAUMA CENTER PAYMENT SURRENDER FORM

1. FACILITY

   Enter the Trauma Center refunding the claim

2. PATIENT NAME

   Enter the patient's name of claim being refunded

3. DATE OF SERVICE

   Enter the patient's date of service

4. TPS#

   Enter the Trauma Patient Sequence Number

5. DATE CLAIM SUBMITTED TO EMS AGENCY

   Enter the date that trauma claim was submitted to EMS

6. AMOUNT OF PAYMENT BEING SURRENDERED

   Enter the amount being refunded to EMS:

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7. PAYMENT RECEIVED FROM

Check appropriate box to Indicate whom provided the refund

☐INSURANCE (Health Plan/HMO)

☐MEDI-CAL

☐MEDICARE

☐PATIENT

☐THIRD PARTY TORTFEASORS

☐OTHER _____

(Specify)

8. DATE COVERAGE IDENTIFIED

Enter the date coverage identified

9. SUBMITTED BY

Enter the name of person submitting the refund

10. DATE

Enter the date of refund

11 ATTACH COPY OF TRAUMA CENTER SURRENDER FORM

This form must be attached to each payment surrender check

12. MAIL REFUND TO

Los Angeles County/Department of Health Services
Finance – Special Program Funds
1000 S. Fremont Avenue
Unit 8, Building A11, 2nd Floor
Alhambra, CA 91803

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA CENTER PAYMENT SURRENDER FORM

1 FACILITY: _____

2 PATIENT NAME: _____

3 DATE OF SERVICE: _____/_____/_____ 4 TPS#: _____

5 DATE CLAIM SUBMITTED TO EMS AGENCY: _____/_____/_____

6 AMOUNT OF PAYMENT BEING SURRENDERED: $_____

7 PAYMENT RECEIVED FROM	**8 DATE COVERAGE IDENTIFIED**
☐INSURANCE (Health Plan/HMO)	_____/_____/_____
☐MEDI-CAL	_____/_____/_____
☐MEDICARE	_____/_____/_____
☐PATIENT	_____/_____/_____
☐THIRD PARTY TORTFEASORS	_____/_____/_____
☐OTHER _____ (Specify)	_____/_____/_____

9 SUBMITTED BY: _____ 10 DATE: _____/_____/_____

11 (THIS FORM MUST BE ATTACHED TO EACH PAYMENT SURRENDER CHECK)

12 Mail to Los Angeles County/Department of Health Services
Finance – Special Program Funds
1000 S. Fremont Avenue
Unit 8, Building A11, 2nd Floor
Alhambra, CA 91803

COUNTY OF LOS ANGELES•DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA CENTER PAYMENT SURRENDER FORM

FACILITY: _____

PATIENT NAME: _____

DATE OF SERVICE: _____/_____/_____ TPS#: _____

DATE CLAIM SUBMITTED TO EMS AGENCY: _____/_____/_____

AMOUNT OF PAYMENT BEING SURRENDERED: $_____

PAYMENT RECEIVED FROM	**DATE COVERAGE IDENTIFIED**
☐INSURANCE (Health Plan/HMO)	_____/_____/_____
☐MEDI-CAL	_____/_____/_____
☐MEDICARE	_____/_____/_____
☐PATIENT	_____/_____/_____
☐THIRD PARTY TORTFEASORS	_____/_____/_____
☐OTHER _____ (Specify)	_____/_____/_____

SUBMITTED BY: _____ **DATE:** _____/_____/_____

(THIS FORM MUST BE ATTACHED TO EACH PAYMENT SURRENDER CHECK)

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1000 S. Fremont Avenue
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