APPLICATION BY PERSONAL REPRESENTATIVE OF DECEASED HEALTH CARE PROVIDER

Email completed form to: ra-in-McareRefundCtr@pa.gov

Health Care Provider	
Name	
Professional License No.	
Estate of Health Care Provider	
Name	
Tax Identification No:	
Mailing address	
Email address	

1. I certify that Health Care Provider is deceased. A copy of the death certificate is attached.

2. I certify that I have been appointed as the Personal Representative for the Estate of Health Care Provider. A copy of the certificate of grant of letters or other court-issued evidence of my appointment, dated within the last sixty days, is attached.

3. I certify that checks for a payment due to the Estate of Deceased Health Care Provider are properly made payable and mailed to the Estate as set forth above.

4. I certify that I have read the Notice for Personal Representatives of Deceased Health Care Providers on the Mcare Website and request Mcare to approve the following:
   - **Refund notice –** The Mcare refund notice for Health Care Provider shall be mailed to Health Care Provider's Estate at the address set forth above.
   - **Claimed refunds** – In the event that an Mcare refund for any line of coverage of Health Care Provider is claimed by a person or entity that paid the assessment, I am authorized to choose who Mcare will pay the refund, in accordance with the claimed refund process.
   - **Assignment** – I am authorized to assign an unclaimed refund for a line of coverage of Health Care Provider to a person or entity that paid the assessment, in accordance with the assignment process.
   - **Payment** – The check for any Mcare refunds payable to Health Care Provider shall be made payable to Health Care Provider's Estate and mailed to its address set forth above.

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Name of Personal Representative

_____

Signature of Personal Representative

_____

Date

Approved by Mcare

_____

Name

_____

Title

_____

Date