APPLICATION BY REPRESENTATIVE OF DISSOLVED HEALTH CARE PROVIDER

Mail original of completed form to: Mcare Fund, Attn: Refund Process Coordinator,
1010 N. 7th Street, Suite 201, PO Box 12030, Harrisburg, PA 17108-2030

Dissolved Health Care Provider	
Name	
Tax Identification No.	
Representative	
Name	
Mailing address	
Email address	
Refund Payee	
Name	
Tax Identification No.	

I swear under penalty of perjury that the following is true and correct:

1. The above identified Health Care Provider has been dissolved and there is no successor entity or buyer of the practice's assets including its receivables. A copy of the Articles of Dissolution is attached if the health care provider was a corporation.

2. I have been authorized, as supported by the attached documentation, to request Mcare to approve the following by the person or persons authorized to wind up the affairs of Health Care Provider:

   - **Refund notice** – The Mcare refund notice for Health Care Provider shall be mailed to me, as the designated Representative, at the address set forth above.

   - **Refund payment** – The check for any Mcare refunds payable to Health Care Provider shall be made payable to the above identified Refund Payee and mailed to me, as the designated Representative, at the address set forth above.

_____
Signature of Representative

_____
Date

Sworn to and subscribed to before me this
____ day of _____, 201__.

_____
Notary Pubic

Approved by Mcare

_____
Name

_____
Title

_____
Date