Emergency Physician Fund

TRAFFIC ACCIDENT ASSISTANCE PROGRAM (TAAP)

4742 N. 24th Street, Suite 300, Phoenix, AZ 85016
Ph: (888) 462-8833 Fax: (800) 498-7077
Email: taap@EmergencyPhysicianFund.com
Web: EmergencyPhysicianFund.com

APPLICATION FORM

Once completed, email application to taap@emergencyphysicianfund.com

TAAP USE ONLY
DATE RECEIVED STAMP

1. PHYSICIAN NAME	2. LICENSE NUMBER
3. STREET ADDRESS	4. MAILING ADDRESS (IF DIFFERENT)
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
5. CONTACT NAME & TITLE	6. PHONE NUMBER
7. EMAIL ADDRESS	8. FAX NUMBER

9. SPECIALTY (MARK ALL THAT APPLY)

- ☐ TRAUMA / EMERGENCY
- ☐ ORTHOPEDIC
- ☐ ANESTHESIA
- ☐ GENERAL
- ☐ NEUROSURGEON
- ☐ ORTHOPEDIC SPINE
- ☐ OTHER: _____

10. SOLE PRACTIONER

- ☐ YES
- ☐ NO

11. IF PART OF MEDICAL GROUP, PLEASE PROVIDE THE FOLLOWING

NAME OF GROUP _____

NUMBER OF TRAUMA & ER PHYSICIANS _____

12. PERFORM TRAUMA OR ER ON-CALL SERVICES

- ☐ YES
- ☐ NO

13. IF SO, AT WHAT FACILITIES:

1. _____
2. _____
3. _____

14. ESTIMATE OF TRAUMA & ER PATIENTS CARED FOR PREVIOUS FISCAL YEAR	15. ESTIMATE OF TRAUMA & ER PATIENTS CARED FOR YEAR TO DATE	16. PERCENTAGE THAT WERE MEDICAID PREVIOUS FISCAL YEAR	17. PERCENTAGE OF YOUR PRACTICE THAT IS TRAUMA OR ER CALL
		%	%

18. ESTIMATE OF UNINSURED / SELF-PAY TRAUMA & ER CARE FOR LAST 24 MONTHS	19. ESTIMATE OF UNREIMBURSED TRAUMA & ER CARE FOR LAST 24 MONTHS
$	$

20. STATEMENT OF NEED - IN THE SPACE BELOW, PLEASE WRITE A BRIEF STATEMENT HOW UNREIMBURSED / SELF-PAY TRAUMA CARE HAS AFFECTED YOUR PRACTICE.

I, THE UNDERSIGNED, DO HEREBY ATTEST THAT THE INFORMATION CONTAINED WITHIN THIS APPLICATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MY APPLICATION WILL BE DISQUALIFIED SHOULD FALSIFIED INFORMATION BE REVEALED.

PRINTED NAME	TITLE
SIGNATURE	DATE