Commonwealth of Pennsylvania



Pennsylvania
Insurance Department

Mcare Assessment Manual

January 1

2027

Josh Shapiro, Governor
Michael Humphreys, Insurance Commissioner

30%

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Commonwealth of Pennsylvania
Insurance Department

Medical Care Availability and Reduction of Error Fund (Mcare)

2027 ASSESSMENT MANUAL

Introduction

This manual should be used to calculate the Mcare assessment for 2027 as required by Act 13 of 2002 ("Act 13"). It is essential that this manual is read in its entirety. While the manual is intended to clarify and periodically modify procedures associated with calculating the assessment, the manual is not a substitute for complying with Act 13 (40 P.S. §§ 1303.101, *et seq.*) and the regulations (31 Pa. Code §§ 242.1, *et seq.*). Although the information in this manual is intended to complement Act 13 and its attending rules and regulations, if a conflict exists, Act 13 and its regulations are controlling.

The Mcare assessment is a percentage of the Pennsylvania Professional Liability Joint Underwriting Association (JUA) rates as approved by the Pennsylvania Insurance Department. The JUA rates to be used for the 2027 Mcare assessment calculation are the base rates that are effective January 1, 2027. It has been determined that the 2027 Mcare assessment rate is 30%.

TIP: CONSULTING THE JUA RATE MANUAL AT WWW.PAJUA.COM MAY PROVIDE DETAILS NOT SPECIFICALLY ADDRESSED IN THIS MANUAL.

MCARE PARTICIPATION

Participation in Mcare is mandatory for hospitals, nursing homes, birth centers, primary health centers, physicians, podiatrists, and certified nurse midwives ("health care providers" or HCPs) licensed in Pennsylvania and conducting 50% or more of their health care business within Pennsylvania. If an HCP is licensed in Pennsylvania and less than 50% but more than 0% of patients to whom the HCP renders healthcare services are in Pennsylvania, the HCP may choose to participate in Mcare. However, if the HCP opts out of participating in Mcare, the HCP must still meet the mandatory insurance requirements of Act 13 of 2002. See the Nonparticipating Transmittal Form e-316. Although not defined as a "health care provider," those professional corporations, professional associations, and professional companies and partnerships that are entirely and directly owned by HCPs and which elect to purchase basic insurance coverage as defined by Section 711 of the Mcare Act, or greater, must also participate in Mcare.

Physicians and podiatrists are only required to participate in Mcare when they become eligible for unrestricted licenses, regardless of whether they apply for the unrestricted license. The relevant licensing boards set postgraduate training requirements to determine when physicians or podiatrists are eligible for unrestricted licenses. The postgraduate training requirements and related license type and prefix are summarized in the table below:

License Type	License Prefix	Training Before Eligible for Unrestricted License
Medical Trainee	MT	2 Years (accredited or unaccredited medical school)
Osteopathic Trainee License	OT	1 Year
Podiatry License	SC	None. Eligible upon grant of license.

(The information in this table is effective July 1, 2022. As a result of Act 16 of 2022, there is no longer a requirement for a third year of residency for medical school students who graduated from an unaccredited medical school. Please contact the relevant licensing board for questions regarding the eligibility of physicians or podiatrists for unrestricted licenses.)

2027 MCARE LIMITS

Act 13 provides that the total required amounts of medical professional liability coverage, including primary and Mcare coverage, for HCPs, excluding hospitals, are $1,000,000 per occurrence and $3,000,000 per annual aggregate. For hospitals, the required total coverage amounts are $1,000,000 per occurrence and $4,000,000 per annual aggregate. As in recent years, Mcare Fund participating HCPs will be required in 2027 to obtain primary coverage in the amount of $500,000 per occurrence and $1,500,000 per annual aggregate. Hospitals must obtain primary coverage in the amount of $500,000 per occurrence and $2,500,000 per annual aggregate. Mcare provides participating HCPs coverage of $500,000 per occurrence and $1,500,000 per annual aggregate in excess of the primary coverage.

EXEMPTIONS

HCPs as defined in the Mcare Act are exempt from participating in Mcare if they exclusively provide care:

- Outside the Commonwealth of Pennsylvania or have not provided care to Pennsylvanians
- As employees of the federal, state or local government including the military
- As a forensic pathologist

If a health care provider also provides care in other than exempted category, they must participate in Mcare for that part(s) of their practice.

HCPs who provide care in the Commonwealth of Pennsylvania may be exempt from participation in Mcare under the following circumstances that include restrictions:

- Less than 50% of the healthcare services provided by the HCP is in Pennsylvania, however, they must still maintain medical malpractice coverage as required by the Mcare Act
- The care provided by the HCP is exclusively within the restrictions of a Volunteer License
- Physicians with Active Retired licenses providing care only to themselves or their immediate family members

Additionally, HCPs without an active license, for whatever reason, who are not providing care are exempt from Mcare participation

TIP: PLEASE ADVISE YOUR EXEMPT NON-PARTICIPATING HCPS TO SUBMIT A DECLARATION OF COMPLIANCE (DOC) FORM TO MCARE. THE DOC CAN BE ACCESSED FROM MCARE'S COMPLIANCE PAGE. IF THE HCP IS EXEMPT FROM PARTICIPATING BECAUSE LESS THAN 50% OF THE CARE PROVIDED IS IN PENNSYLVANIA, THEY SHOULD SUBMIT A DOC OR THE PRIMARY INSURER SHOULD SUBMIT A FORM E-316.

CONTACTING MCARE

This manual addresses assessment calculation issues that most commonly arise. The principles contained in this manual can also be applied to many novel situations. After reading this manual, anyone with questions regarding calculation of the Mcare assessment should submit their questions in writing to Mcare.

USPS Mailing Address:
Mcare
Division of Coverage
P.O. Box 566
Harrisburg, PA 17108-0566

For Non-USPS Deliveries:
Mcare
Division of Coverage
Capitol Associates Building
901 N. 7th St., 3rd Floor
Harrisburg, PA 17102

Phone: (717) 783-3770

Form e-216 submission e-mail:
ra-in-remittance@pa.gov

Mcare Coverage inquiries e-mail:
ra-in-mcare-policy-web@pa.gov

SECTION I - REMITTANCE ADVICE FORM (Form e-216)

A. GENERAL INFORMATION Form e-216 serves as both a coverage reporting form and an accounting form. Electronic submission of the Excel Form e-216 is the preferred method for primary insurers and self-insurers to report basic insurance coverage to Mcare. Prior written permission must be obtained from Mcare before alternate electronic submissions will be accepted. Although a hard copy Form 216 will be accepted in isolated circumstances that are preapproved by Mcare, submitting both an electronic and hard copy of the same Form 216 is unacceptable.

Always download a new Form e-216 from our website each time you need to complete another Form e-216. Mcare periodically improves Form e-216. Downloading a new Form e-216 each time will ensure the latest version is used. Form e-216, along with all applicable Worksheet Exhibits, is available by:

1. Visiting our website at www.insurance.pa.gov
2. Clicking on "MCARE" near the bottom of the page under "Special Funds"
3. Clicking on the arrow in the "Coverage" tile under "Overview of Mcare"
4. Selecting the link for the appropriate year's assessment manual
5. Selecting the "e-216 Remittance Advice Form" link under "Reporting"
6. Opening or saving the file

Form e-216 is a Microsoft Excel Macro-Enabled Worksheet (.xlsm). Macros must be enabled to ensure that Form e-216 works as intended. Please keep the file in .xlsm format to preserve functionality.

Form e-216 calculates the assessment payable for physicians, podiatrists and certified nurse midwives based on the information provided in columns "A" through "N." Facility and entity worksheets are tabbed at the bottom of Form e-216. These required worksheets will calculate the assessment for hospitals (HS WS), corporations (MC WS), birth centers (BC WS), nursing homes (NC WS), and primary health centers (PC WS). The coverage data entered on these worksheets can be transferred to the e-216 automatically using the Transfer to e-216 button. Additionally, a Facility/Entity Credit Calculator is available on Form e-216 to assist with cancelling facilities and entities. See the Mcare e-216 Tools Manual for further information on the Transfer to e-216 button and Facility/Entity Credit Calculator; this manual can be found on our website alongside the 2027 Assessment Manual and e-216.

The 2027 Form e-216 is to be used to report coverage only for policies issued or renewed in 2027. This is because the 2027 Form e-216 will calculate the assessment based on 2027 rates. When reporting mid-term additions and deletions to an existing master policy, use the effective year of the master policy to determine the applicable assessment year and rates.

NOTE: FORM E-216 IS A TOOL TO ASSIST IN THE CALCULATION OF THE ASSESSMENT; HOWEVER, ALL ASSESSMENTS MUST BE REVIEWED FOR ACCURACY BEFORE SUBMITTING TO MCARE. TRANSACTIONS SHOULD BE REPORTED AND RECEIVED AT MCARE IN CHRONOLOGICAL ORDER.

Coverage information along with collected assessment payments, if applicable, should be received by Mcare within 60 calendar days of the effective date of coverage in order to be considered timely. Failure to pay a sufficient assessment within 60 calendar days of the effective date of coverage may result in disciplinary action against an HCP's medical license and the denial of Mcare coverage in the event of a claim against the HCP or eligible entity.

B. PAYMENT If payment is due, the payment must be sent to Mcare at or about the same time as the e-216 is e-mailed, but within 60 calendar days of the effective date of coverage. When money is due to Mcare, the check, ACH or wire number and payment amount must be included in the Form e-216 and the insurer code must be included on the face of the check or in the designated space of your ACH or wire so we can match the e-216 with the payment. **Please make payments payable to: Medical Care Availability and Reduction of Error Fund or "Mcare". The check, ACH or wire received by Mcare must be issued by the insurer, producer, or broker, not the insured health care providers. The payment can only be applied to a single insurer code. Please do not send a payment that is applicable across multiple insurer codes.**

Setting Up Electronic Payment Assessment payments may be made through an electronic funds transfer (EFT) payment process. The EFT payment method is an alternative to the check payment method. To learn more about this payment option and the required minimum standards, please send an e-mail to Mcare's Fiscal Unit at ra-in-mcare-exec-web@pa.gov expressing your interest.

If payment is due with your Form e-216, the assessment total must be equal to the payment amount remitted unless the primary insurer or self-insurer has a prior credit balance and it is properly documented on the e-216. If utilizing a credit, the payment amount should equal the amount due. For more information on credit balances and tracking them on the e-216, please see page 7.

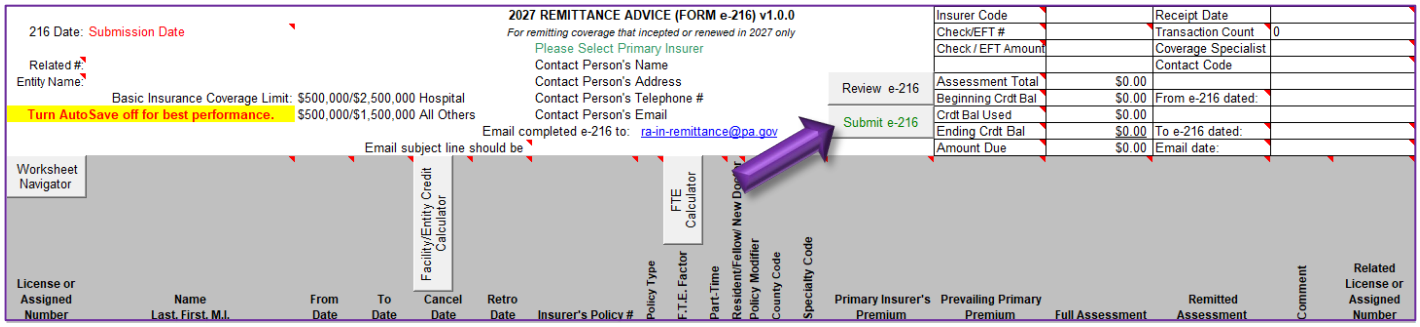
NOTE: WHEN PAYMENT IS DUE WITH AN E-216, THE "RECEIPT DATE" IS THE DATE THE FULL PAYMENT HAS BEEN RECEIVED BY MCARE. WHEN NO PAYMENT IS DUE WITH AN E-216, THE "RECEIPT DATE" IS THE DATE THE VALID E-216 IS RECEIVED BY MCARE.

C. ELECTRONIC SUBMISSIONS Electronic submission of Form e-216 is the preferred method of reporting basic insurance coverage to Mcare. A hard copy 216 is no longer required when submitting your e-216 with or without payment. The e-216 and accompanying documentation must be sent to ra-in-remittance@pa.gov. **The 216 Date in cell B2 must match the date you are emailing your electronic submission to Mcare.**

When remitting to Mcare, please include the following in your e-mail:

- A subject line with proper formatting. **Proper subject line formatting for your e-216 submission** is very important as your e-mail will be sorted based upon this information. The correct subject line is automatically populated on your e-216 in cell G9 and may be copied and pasted to your email.
- A brief description of what is being submitted in the body of the e-mail.
- An attached Form e-216 with credit balances being tracked when appropriate.
- Supporting documentation provided as separate attachments.

The above requirements can be met easily using the **Submit e-216** button seen on the next page. Clicking this button will create an email with the appropriate subject line, a brief description of your submission, and a copy of your Form e-216 attached. If you are submitting multiple e-216s or need to include any supporting documentation, these will need to be attached to the email manually. For more on the Submit e-216 button, see the Mcare e-216 Tools Manual; this manual can be found on our website alongside the 2027 Mcare Assessment Manual and e-216.



"Submit e-216" button.

Additional information on electronic submissions:

- The Commonwealth of Pennsylvania's e-mail system will not accept an e-mail with a file size of 30 megabytes (MB) or larger. Contact your Coverage Specialist if you have a submission over 30 MB.

- Do not use the recall feature to cancel an incorrect submission. Once it is received, it is considered an official submission. If you need to make a change to a submission that was already e-mailed to ra-in-remittance@pa.gov please contact your Mcare Coverage Specialist for further instructions.

TIP: PLEASE ALLOW 2 HOURS TO RECEIVE A CONFIRMATION FOR E-216S SUBMITTED TO THE RA-IN-REMITTANCE@PA.GOV E-MAIL ADDRESS. ISSUES WITH INTERNET SERVICE PROVIDERS, E-MAIL PROVIDERS, NETWORK TRAFFIC, AND SERVER/MAILBOX CAN DEGRADE TRANSMISSION OF E-MAILS. IF YOU DO NOT RECEIVE A CONFIRMATION AFTER 2 HOURS, PLEASE NOTIFY YOUR MCARE COVERAGE SPECIALIST.

SECTION II - REPORTING GUIDELINES

A. CREDIT BALANCES When the total of a Form e-216 results in a credit that is due to the insurer, the credit will be used as payment toward a future Form e-216. All credit balances must be carried forward to the next Form e-216 until the credit balance is exhausted. Credit balances belong to the insurer of record and one credit balance per insurer may be maintained. The heading of the Form e-216 tracks credit balances. Please enter data in the specified fields as outlined below:

	P	Q	S	U	V
1	Insurer Code		Receipt Date		
2	Check/EFT #		Transaction Count	0	
3	Check / EFT Amount		Coverage Specialist		
4			Contact Code		
5	Assessment Total	$0.00			
6	Beginning Crdt Bal	$0.00	From e-216 dated:		
7	Crdt Bal Used	$0.00			
8	Ending Crdt Bal	$0.00	To e-216 dated:		
9	Amount Due	$0.00	Email date:		

Key:
Entered by submitter
Automatically populated
For Mcare's official use only

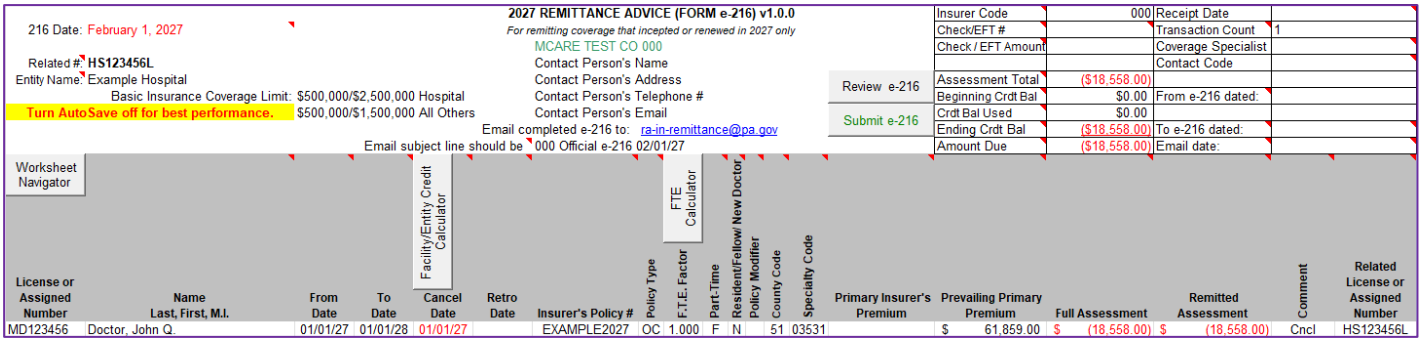
Form e-216 header assessment/credit tracking.

Form e-216 header assessment/credit tracking field descriptions:

- Insurer Code (Cell Q1) – Insurer code selected from drop down box
- Check/EFT # (Cell Q2) – Check/EFT # must be entered if sending payment. Please only enter letters and numbers, no spaces or symbols.

- Check/EFT Amount (Cell Q3) – Enter the amount of the check. This should match the Amount Due. The Check/EFT Amount should be equal to the Assessment Total minus the credit balance being used
- Assessment Total (Cell Q5) – This is the e-216 total
- Beginning Crdt Bal (Cell Q6) – Enter your current credit balance as a **credit**
- Crdt Bal Used (Cell Q7) – Enter amount of credit being applied to this submission as a **debit**
- Ending Crdt Bal (Cell Q8) – This is the credit balance that should be carried over to your next e-216
- Amount Due (Cell Q9) – This will be the amount due or the new credit balance
- Transaction Count (Cell U2) – The number of transactions on this e-216
- From e-216 Dated (Cell U6) – Enter the e-216 date the credit balance is being transferred from our preferred method is one e-216 per submission. Multiple e-216s per submission are acceptable, but completion of the header assessment/credit tracking information may become more complex

The following examples show various transactions involving credit balance adjustments. This first example shows a credit balance being generated where none previously existed:



2027 REMITTANCE ADVICE (FORM e-216) v1.0.0

For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027

Related #: **HS123456L**

Entity Name: Example Hospital

Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital

Turn AutoSave off for best performance. $500,000/$1,500,000 All Others

MCARE TEST CO 000

Contact Person's Name

Contact Person's Address

Contact Person's Telephone #

Contact Person's Email

Email completed e-216 to: ra-in-remittance@pa.gov

Email subject line should be 000 Official e-216 02/01/27

Review e-216 | Submit e-216

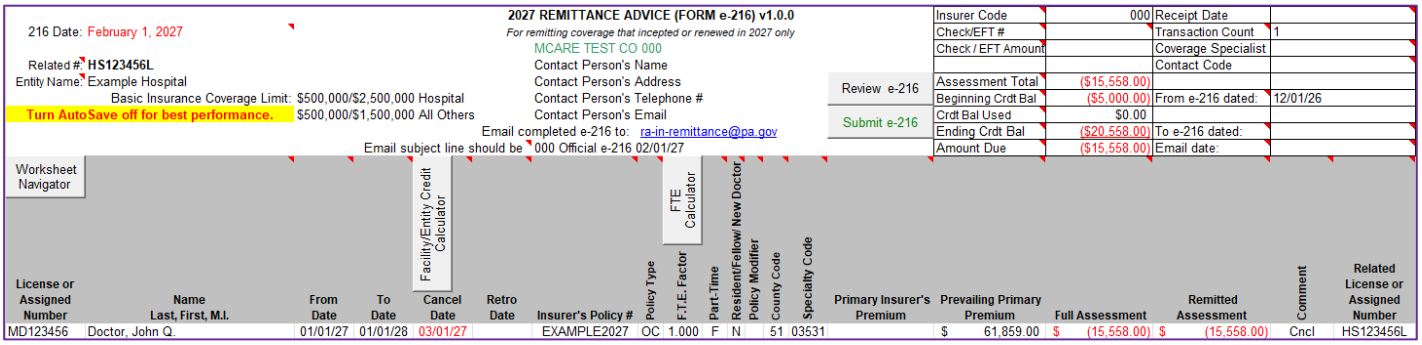
Insurer Code	000	Receipt Date	
Check/EFT #		Transaction Count	1
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	($18,558.00)		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	($18,558.00)	To e-216 dated:	
Amount Due	($18,558.00)	Email date:	

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28	01/01/27		EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ (18,558.00)	$ (18,558.00)	Cncl	HS123456L

This remittance results in an Assessment Total credit of ($18,558.00). The insurer has no Beginning Credit Balance, so their new Ending Credit Balance is ($18,558.00).

The second example below shows a credit balance being generated and added to an existing credit balance:



2027 REMITTANCE ADVICE (FORM e-216) v1.0.0

For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027

Related #: **HS123456L**

Entity Name: Example Hospital

Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital

Turn AutoSave off for best performance. $500,000/$1,500,000 All Others

MCARE TEST CO 000

Contact Person's Name

Contact Person's Address

Contact Person's Telephone #

Contact Person's Email

Email completed e-216 to: ra-in-remittance@pa.gov

Email subject line should be 000 Official e-216 02/01/27

Review e-216 | Submit e-216

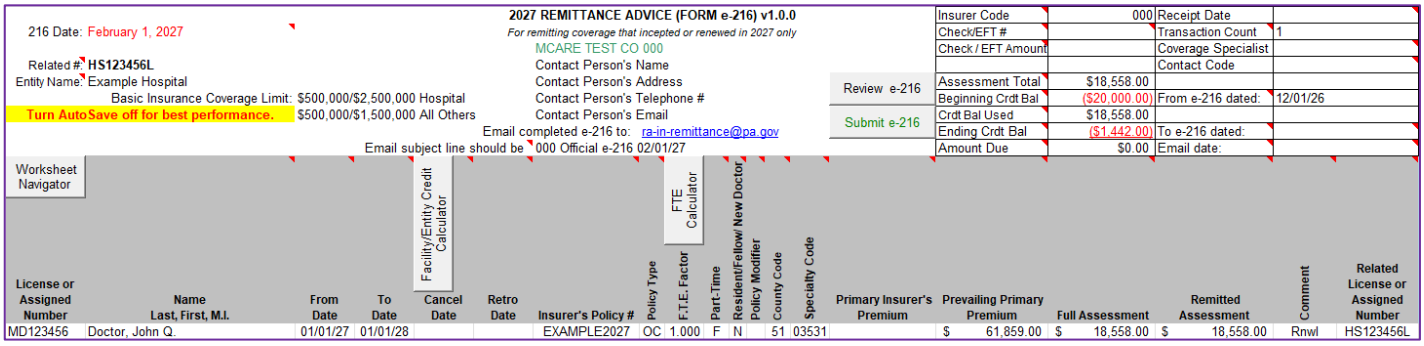
Insurer Code	000	Receipt Date	
Check/EFT #		Transaction Count	1
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	($15,558.00)		
Beginning Crdt Bal	($5,000.00)	From e-216 dated:	12/01/26
Crdt Bal Used	$0.00		
Ending Crdt Bal	($20,558.00)	To e-216 dated:	
Amount Due	($15,558.00)	Email date:	

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28	03/01/27		EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ (15,558.00)	$ (15,558.00)	Cncl	HS123456L

This remittance results in an Assessment Total credit of ($15,558.00). The insurer has a Beginning Credit Balance of ($5,000.00) from their remittance dated 12/01/26. They are adding the credit generated by this submission to their Beginning Credit Balance and carrying forward a new Ending Credit Balance of ($20,558.00).

In the next example, the submission's entire Assessment Total is being paid with an existing credit balance:



216 Date: February 1, 2027

Related #: **HS123456L**
Entity Name: Example Hospital
Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital
Turn AutoSave off for best performance. $500,000/$1,500,000 All Others

2027 REMITTANCE ADVICE (FORM e-216) v1.0.0
For remitting coverage that incepted or renewed in 2027 only
MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email
Email completed e-216 to: ra-in-remittance@pa.gov
Email subject line should be 000 Official e-216 02/01/27

Review e-216 | Submit e-216

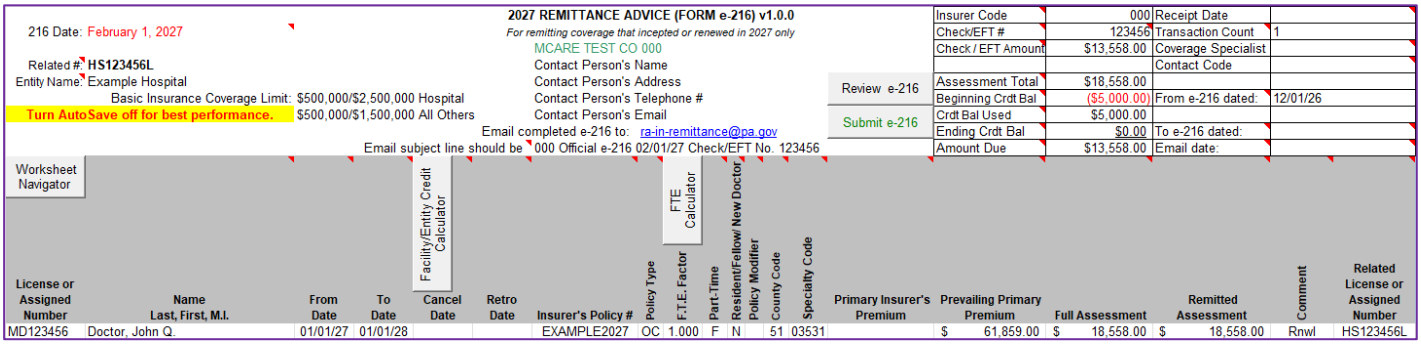
Insurer Code	000	Receipt Date	
Check/EFT #		Transaction Count	1
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	$18,558.00		
Beginning Crdt Bal	($20,000.00)	From e-216 dated:	12/01/26
Crdt Bal Used	$18,558.00		
Ending Crdt Bal	($1,442.00)	To e-216 dated:	
Amount Due	$0.00	Email date:	

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28			EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ 18,558.00	$ 18,558.00	Rnwl	HS123456L

This remittance results in an Assessment Total of $18,558.00. The insurer has a Beginning Credit Balance of ($20,000.00) from their remittance dated 12/01/26. They are using their Beginning Credit Balance to pay the Assessment Total of this submission and carrying forward a new Ending Credit Balance of ($1,442.00).

In this final example, only part of the Assessment Total is being paid with an existing credit balance and the remaining Amount Due is being paid with a check:



216 Date: February 1, 2027

Related #: **HS123456L**
Entity Name: Example Hospital
Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital
Turn AutoSave off for best performance. $500,000/$1,500,000 All Others

2027 REMITTANCE ADVICE (FORM e-216) v1.0.0
For remitting coverage that incepted or renewed in 2027 only
MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email
Email completed e-216 to: ra-in-remittance@pa.gov
Email subject line should be 000 Official e-216 02/01/27 Check/EFT No. 123456

Review e-216 | Submit e-216

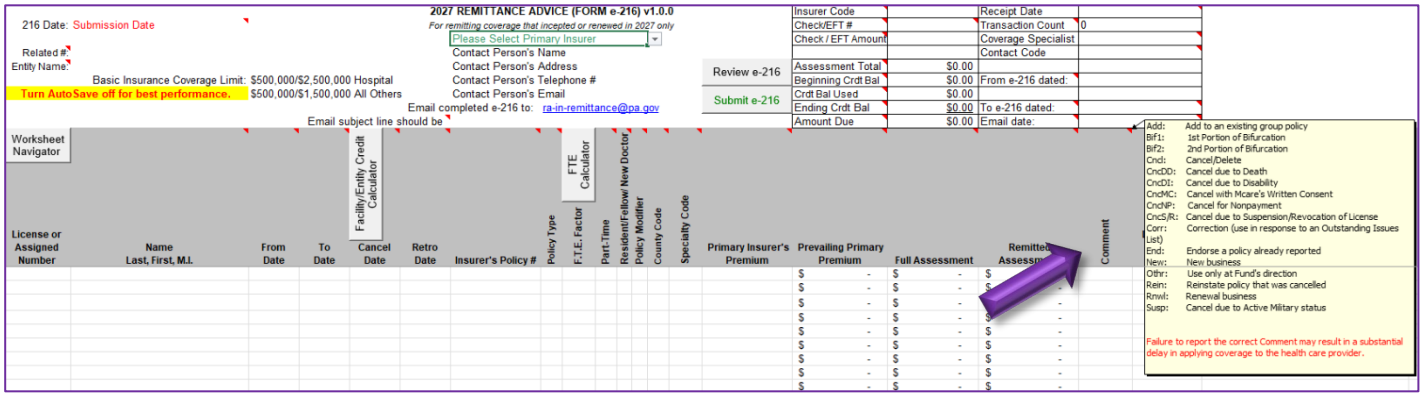
Insurer Code	000	Receipt Date	
Check/EFT #	123456	Transaction Count	1
Check / EFT Amount	$13,558.00	Coverage Specialist	
		Contact Code	
Assessment Total	$18,558.00		
Beginning Crdt Bal	($5,000.00)	From e-216 dated:	12/01/26
Crdt Bal Used	$5,000.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$13,558.00	Email date:	

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28			EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ 18,558.00	$ 18,558.00	Rnwl	HS123456L

This remittance results in an Assessment Total of $18,558.00. The insurer has a Beginning Credit Balance of ($5,000.00) from their remittance dated 12/01/26. They are using their Beginning Credit Balance to offset this submission's Assessment Total resulting in an Amount Due of $13,558.00. The Ending Credit Balance is $0.00.

B. COMMENT COLUMN The Comment column is a required field and must be completed on each coverage line of the Form e-216. It is very important that this information be accurate. Please be mindful to use the "New" comment only for business that is new to your company. Please use the "Rnwl" comment only for business that is a renewal. (Example: HCP is with "Company A" 1/1/23-1/1/24, and then renews with same company for 1/1/24-1/1/25; coverage should be reported as "Rnwl".) Please use the "Cncl" comment only when basic insurance coverage is actually being cancelled. A description of each comment can be found on the Form e-216 by placing your cursor on the red triangle at the top of the Comment column.



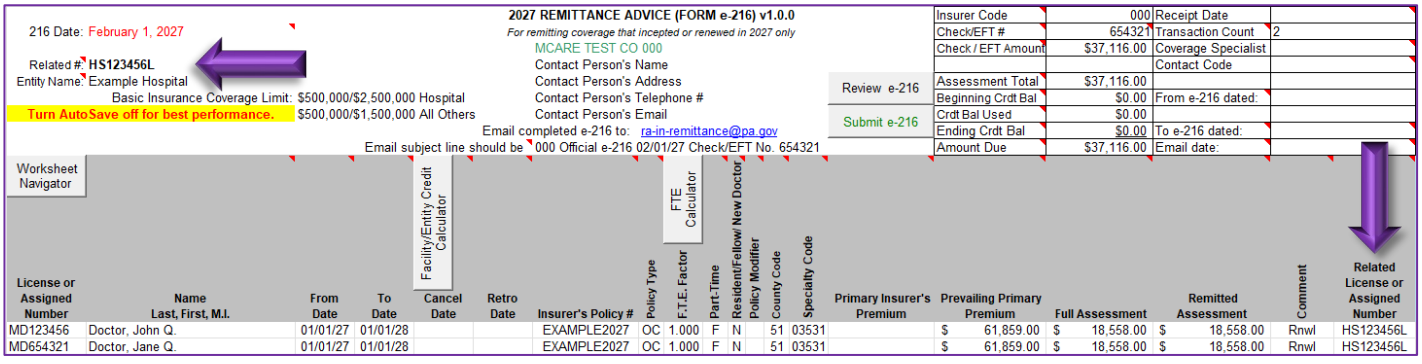
Comment column on the e-216.

C. RELATED LICENSE AND ASSIGNED NUMBERS If there is a relationship of some type between licensed HCPs, put the license number in the Related License or Assigned Number column. Mcare assigns numbers ("Assigned Number") to identify specific hospitals (HS), corporations (MC), or groups (GP). Mcare also assigns a GP number to a nonparticipating entity whenever a group of HCPs are reported under the same policy. Mcare identifies the specific related hospital, corporation, or group that individual HCPs are employed by or affiliated with for rating and statistical purposes. Find assigned entity or group numbers by:

1. Visiting our website at www.insurance.pa.gov
2. Clicking on "MCARE" near the bottom of the page under "Special Funds"
3. Clicking on the arrow in the "Coverage" tile under "Overview of Mcare"
4. Navigating to the "Assigned Entity or Group Numbers" section
5. Selecting the link for the appropriate entity or group type

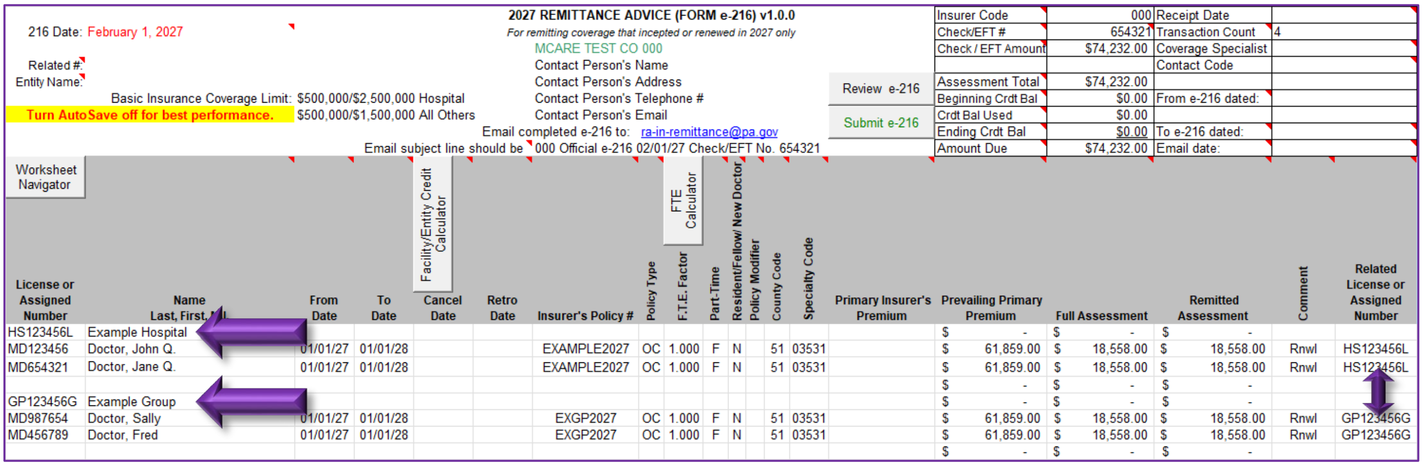
If an assigned number is not found on our website, input "TBD" (To Be Determined) in the "Related License or Assigned Number" column only if you believe you will not meet the 60 calendar day reporting requirement. Please reach out to your assigned Coverage Specialist to obtain a new assigned number.

When submitting a Form e-216 for HCPs employed by the same entity or group, indicate the Related License or Assigned Number in the Related # field at the top of the Form e-216 (cell B4). This will automatically populate the Related License or Assigned Number in the V column on the Form e-216. Complete cell B5 with the entity or group name.



Single Mcare Related License or Assigned Number.

If submitting a Form e-216 with multiple Related License or Assigned Numbers, please type the related number in column V for each line of coverage with an affiliation. One continuous Form e-216 per remittance should be e-mailed regardless of how many Related License or Assigned Numbers are reported. If this is problematic, please contact the Coverage Specialist who handles your account. Please type the corresponding name of the hospital, corporation, or group as a heading in the name column on the line above each group of HCPs having the same Related License or Assigned Number.



2027 REMITTANCE ADVICE (FORM e-216) v1.0.0

For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027

Related #:

Entity Name:

Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital

$500,000/$1,500,000 All Others

Turn AutoSave off for best performance.

MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email

Email completed e-216 to: ra-in-remittance@pa.gov

Email subject line should be 000 Official e-216 02/01/27 Check/EFT No. 654321

Review e-216 | Submit e-216 | Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

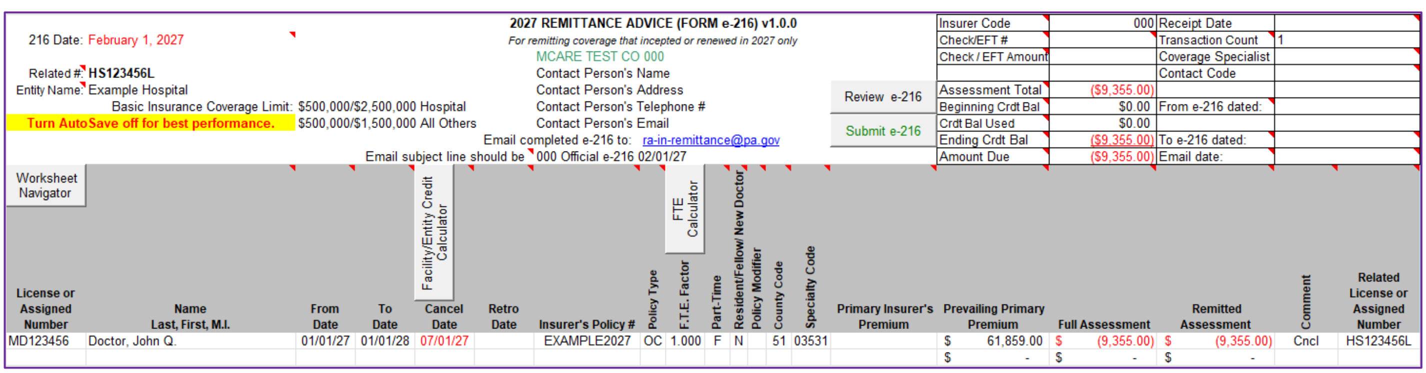
Insurer Code	000	Receipt Date	
Check/EFT #	654321	Transaction Count	4
Check / EFT Amount	$74,232.00	Coverage Specialist	
		Contact Code	
Assessment Total	$74,232.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$74,232.00	Email date:	

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
HS123456L	Example Hospital														$ -	$ -	$ -		
MD123456	Doctor, John Q.	01/01/27	01/01/28			EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ 18,558.00	$ 18,558.00	Rnwl	HS123456L
MD654321	Doctor, Jane Q.	01/01/27	01/01/28			EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ 18,558.00	$ 18,558.00	Rnwl	HS123456L
															$ -	$ -	$ -		
GP123456G	Example Group														$ -	$ -	$ -		
MD987654	Doctor, Sally	01/01/27	01/01/28			EXGP2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ 18,558.00	$ 18,558.00	Rnwl	GP123456G
MD456789	Doctor, Fred	01/01/27	01/01/28			EXGP2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ 18,558.00	$ 18,558.00	Rnwl	GP123456G
															$ -	$ -	$ -		

Multiple Mcare Related License or Assigned Numbers.

D. CANCELLATIONS (Cncl) should be reported when the primary coverage cancels. Cancellations must be received by Mcare within 60 calendar days of the effective date of the cancellation to receive credit. To report a cancellation:

1. Enter the full original coverage period in the coverage "From Date" and "To Date" and the cancellation effective date in the cancel date column.
2. Complete all other applicable coverage information.
3. The Form e-216 will calculate the return assessment credit.
4. Cncl should be coded in the Comment column of Form e-216.



2027 REMITTANCE ADVICE (FORM e-216) v1.0.0

For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027

Related #: HS123456L

Entity Name: Example Hospital

Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital

$500,000/$1,500,000 All Others

Turn AutoSave off for best performance.

MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email

Email completed e-216 to: ra-in-remittance@pa.gov

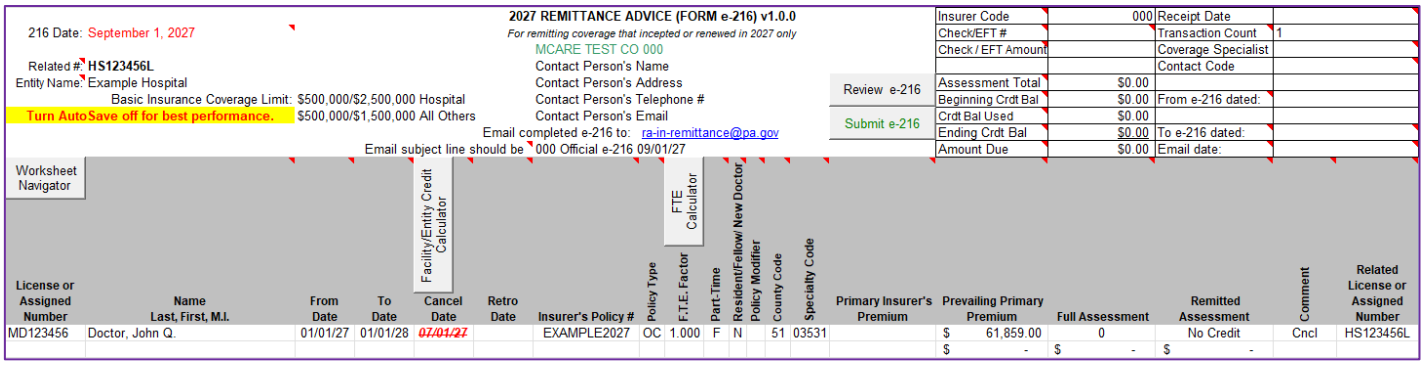
Email subject line should be 000 Official e-216 02/01/27

Review e-216 | Submit e-216 | Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

Insurer Code	000	Receipt Date	
Check/EFT #		Transaction Count	1
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	($9,355.00)		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	($9,355.00)	To e-216 dated:	
Amount Due	($9,355.00)	Email date:	

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28	07/01/27		EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ (9,355.00)	$ (9,355.00)	Cncl	HS123456L
															$ -	$ -	$ -		

John Q. Doctor was cancelled effective 7/01/27, generating a ($9,355.00) credit.



2027 REMITTANCE ADVICE (FORM e-216) v1.0.0
For remitting coverage that incepted or renewed in 2027 only

216 Date: September 1, 2027
Related #: HS123456L
Entity Name: Example Hospital
Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital
Turn AutoSave off for best performance. $500,000/$1,500,000 All Others
MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email
Email completed e-216 to: ra-in-remittance@pa.gov
Email subject line should be 000 Official e-216 09/01/27

Review e-216
Submit e-216

Insurer Code	000	Receipt Date	
Check/EFT #		Transaction Count	1
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	$0.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$0.00	Email date:	

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28	~~07/01/27~~		EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	0	No Credit	Cncl	HS123456L
															$ -	$ -	$ -		

John Q. Doctor was cancelled effective 7/01/27. However, since this cancellation was submitted late, no credit is generated.

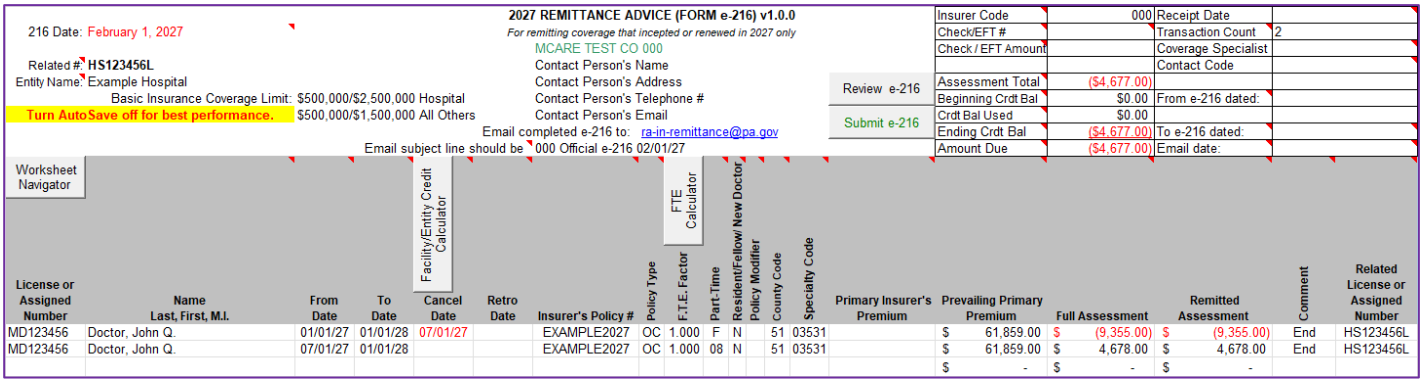
NOTE: IF THE DATE IN THE CANCEL DATE FIELD IS BOLD, ITALIC, AND LINED THROUGH (I.E., ~~*07/01/27*~~), THE DATE IN THE CANCEL DATE FIELD IS NOT WITHIN 60 DAYS OF THE 216 DATE. FORM E-216 WILL INDICATE "NO CREDIT" FOR LATE CANCELLATIONS. CREDITS WILL ONLY BE PERMITTED WHEN CANCELLATIONS ARE TIMELY REPORTED WITHIN 60 CALENDAR DAYS FROM THE DATE OF THE CANCELLATION. CANCELLATIONS SUBMITTED AFTER THE REGULATORY TIME PERIOD WILL NOT GENERATE A CREDIT BUT WILL BE PROCESSED AND MCARE RECORDS UPDATED, UNLESS THE CANCELLATION CREATES A COMPLIANCE ISSUE FOR THE HEALTH CARE PROVIDER.

TIP: MCARE RECOMMENDS THAT THE PRIMARY INSURER NOTIFY ANY PARTIES RESPONSIBLE TO GIVE NOTICE OF CANCELLATION (INSUREDS, BROKERS, ETC.) IN A TIMELY MANNER, ALLOWING SUFFICIENT TIME TO SUBMIT IT TO MCARE WITHIN 60 CALENDAR DAYS OF THE CANCELLATION EFFECTIVE DATE.

NOTE: IF YOU ARE REPORTING AN UPDATED CANCELLATION DATE AFTER A REINSTATEMENT ("ADJUSTED CANCELLATION"), AND THE ORIGINAL AND/OR UPDATED CANCELLATION ARE NOT TIMELY, PLEASE REACH OUT TO YOUR MCARE COVERAGE SPECIALIST FOR GUIDANCE ON HOW TO TRACK ANY CREDITS OR DEBITS.

E. ENDORSEMENTS (End) are changes to previously reported coverage and typically require the use of two lines of the Form e-216 to calculate the assessment. To report an endorsement:

1. The first line is a simulation of a cancellation of the previously reported coverage. Enter the full original coverage period in the coverage "From Date" and "To Date" and the endorsement effective date in the "Cancel Date" column.
2. On the second line, use the endorsement effective date as the "From Date" and the expiration date as the "To Date" and complete the Form e-216 with the amended coverage information.
3. Both lines should be coded as End in the Comment column of Form e-216.



2027 REMITTANCE ADVICE (FORM e-216) v1.0.0
For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027
Related #: HS123456L
Entity Name: Example Hospital
Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital
Turn AutoSave off for best performance. $500,000/$1,500,000 All Others
MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email
Email completed e-216 to: ra-in-remittance@pa.gov
Email subject line should be 000 Official e-216 02/01/27

Review e-216
Submit e-216

Insurer Code	000	Receipt Date	
Check/EFT #		Transaction Count	2
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	($4,677.00)		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	($4,677.00)	To e-216 dated:	
Amount Due	($4,677.00)	Email date:	

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28	07/01/27		EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ (9,355.00)	$ (9,355.00)	End	HS123456L
MD123456	Doctor, John Q.	07/01/27	01/01/28			EXAMPLE2027	OC	1.000	08	N		51	03531		$ 61,859.00	$ 4,678.00	$ 4,678.00	End	HS123456L
															$ -	$ -	$ -		

John Q. Doctor was endorsed effective 7/01/27 from full-time to part-time 08.

F. CORRECTIONS (Corr) are typically reported in a similar manner to endorsements, i.e. the use of two lines on Form e-216. To report a correction:

1. Reverse what was originally reported incorrectly on the first line.
2. On the second line, enter the corrected coverage information.
3. Both lines should be coded as Corr in the Comment column of Form e-216 unless instructed otherwise by a Coverage Specialist.

2027 REMITTANCE ADVICE (FORM e-216) v1.0.0
For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027
Related #: HS123456L
Entity Name: Example Hospital
Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital
Turn AutoSave off for best performance. $500,000/$1,500,000 All Others
MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email
Email completed e-216 to: ra-in-remittance@pa.gov
Email subject line should be 000 Official e-216 02/01/27

Review e-216 | Submit e-216

Insurer Code	000	Receipt Date			
Check/EFT #		Transaction Count	2		
Check / EFT Amount		Coverage Specialist			
		Contact Code			
Assessment Total	$0.00				
Beginning Crdt Bal	$0.00	From e-216 dated:			
Crdt Bal Used	$0.00				
Ending Crdt Bal	$0.00	To e-216 dated:			
Amount Due	$0.00	Email date:			

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28	01/01/27	01/01/12	EXAMPLE2027	CM	1.000	F	N		51	03531		$ 61,859.00	$ (18,558.00)	$ (18,558.00)	Corr	HS123456L
MD123456	Doctor, John Q.	01/01/27	01/01/28		01/01/13	EXAMPLE2027	CM	1.000	F	N		51	03531		$ 61,859.00	$ 18,558.00	$ 18,558.00	Corr	HS123456L

John Q. Doctor was reported with an incorrect retro date of 1/01/12. His correct retro date is 1/01/13.

Corrections should only be submitted in response to an Outstanding Issues List received from Mcare. A correction is a new transaction and should be entered on a new Form e-216. In other words, it is not acceptable to simply update an erroneous submission and resubmit it. The Form e-216 containing the correction(s) is not a replacement, but a new submission that should contain only new transactions; a new 216 Date should be listed in Cell B2. Submitting a copy of the Outstanding Issues List along with the Form e-216 containing a correction is not necessary.

Please note that failure to provide correct information or full payment to Mcare may result in a health care provider being reported to their licensing authority for no coverage.

G. REINSTATEMENTS (Rein) should be reported to reinstate a policy that was previously cancelled. To report a reinstatement:

1. Enter the originally reported cancellation date in the coverage "From Date" and the original policy end date in the coverage "To Date" fields.
2. Complete all other applicable coverage information.
3. The Form e-216 will calculate the assessment due which will offset the credit generated from the previously reported cancellation.
4. Rein should be coded in the Comment column of Form e-216.

2027 REMITTANCE ADVICE (FORM e-216) v1.0.0
For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027
Related #: HS123456L
Entity Name: Example Hospital
Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital
Turn AutoSave off for best performance. $500,000/$1,500,000 All Others
MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email
Email completed e-216 to: ra-in-remittance@pa.gov
Email subject line should be 000 Official e-216 02/01/27 Check/EFT No. 246810

Review e-216 | Submit e-216

Insurer Code	000	Receipt Date			
Check/EFT #	246810	Transaction Count	1		
Check / EFT Amount	$9,355.00	Coverage Specialist			
		Contact Code			
Assessment Total	$9,355.00				
Beginning Crdt Bal	$0.00	From e-216 dated:			
Crdt Bal Used	$0.00				
Ending Crdt Bal	$0.00	To e-216 dated:			
Amount Due	$9,355.00	Email date:			

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	07/01/27	01/01/28			EXAMPLE2027	OC	1.000	F	N		51	03531		$ 61,859.00	$ 9,355.00	$ 9,355.00	Rein	HS123456L

John Q. Doctor's 1/01/27 – 1/01/28 policy was originally cancelled effective 7/01/27, which resulted in a credit of ($9,355.00). This policy is being reinstated effective 7/01/27, resulting in a debit of $9,355.00, and effectively removes the previously reported cancellation.

NOTE: REINSTATEMENTS REPORTED TO REVERSE UNTIMELY CANCELLATIONS WHERE $0 CREDIT WAS GENERATED IS CONSIDERED A NON-MONEY TRANSACTION WHEN REPORTING TO MCARE.

SECTION III - CALCULATING THE MCARE ASSESSMENT

Mcare assessment payments are to be sent to Mcare at the same time as the Form e-216 and any other required documents are e-mailed. Always download a new e-216 from our website each time you need to complete another e-216. This section is designed to assist in the manual calculation of the Mcare assessment for the various types of HCPs and eligible entities participating in Mcare.

A. PHYSICIANS, PODIATRISTS, AND CERTIFIED NURSE MIDWIVES

REQUIRED FORM: **EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)**

NOTE: PENNSYLVANIA LAW REQUIRES PHYSICIANS, PODIATRISTS, AND CERTIFIED NURSE MIDWIVES TO HAVE FULL ANNUALIZED, SEPARATE, AND INDIVIDUAL LIMITS AND MAY NOT SHARE LIMITS WITH ANY OTHER INSURED.

1. Determine the appropriate classification. When two or more classifications are applicable to the coverage being reported, the assessment for the highest rated classification will apply. (Refer to Exhibit 3)

2. Determine the appropriate territory. When two or more territories are applicable to the coverage being reported, the assessment for the highest rated territory will apply. (Refer to Exhibit 11)

3. Locate appropriate prevailing primary premium. The assessment for a physician, podiatrist, or certified nurse midwife must be calculated by multiplying the prevailing primary premium by the 2027 annual assessment rate of 30%. (Refer to Exhibit 1)

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Submit a completed Form e-216.

B. PROFESSIONAL CORPORATIONS, ASSOCIATIONS AND COMPANIES, AND PARTNERSHIPS (SPECIALTY CODE 80999)

REQUIRED FORMS: **EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)**
EXHIBIT 5 (WORKSHEET FOR PROFESSIONAL CORPORATIONS, ASSOCIATIONS AND COMPANIES, AND PARTNERSHIPS)

NOTE: PENNSYLVANIA LAW PROHIBITS PROFESSIONAL CORPORATIONS, ASSOCIATIONS AND COMPANIES, AND PARTNERSHIPS, AS DEFINED IN PENNSYLVANIA BUSINESS LAWS, FROM SHARING LIMITS WITH ANY HEALTH CARE PROVIDER. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A PARTICIPATING PROFESSIONAL CORPORATION, ASSOCIATION, AND COMPANY OR PARTNERSHIP.

Although not defined as a "health care provider," those professional corporations, professional associations, and professional companies (i.e., a limited liability company that renders professional medical services) and partnerships (i.e., a partnership that renders professional medical services) as defined in Pennsylvania business laws that are entirely and directly owned by HCPs and which elect to purchase basic insurance coverage as defined by Section 711 of the Mcare Act, or greater, must also participate in Mcare.

TIP: PROFESSIONAL CORPORATIONS AND COMPANIES THAT ELECT TO PURCHASE BASIC INSURANCE COVERAGE OR GREATER AND PARTICIPATE IN MCARE ON A CLAIMS MADE BASIS SHOULD BE ADVISED THAT CLAIMS MADE AFTER THE EXPIRATION OF THE COVERAGE WILL NOT BE COVERED BY MCARE UNLESS TAIL OR ITS SUBSTANTIAL EQUIVALENT IS REPORTED.

Proof of Mcare eligibility is required for any entity that is newly reported to Mcare or that changes its professional corporation, professional association, or partnership status. Copies of the articles of incorporation filed and stamped with the Pennsylvania Department of State's endorsement and a list of owners and shareholders or members are required for professional corporations, professional associations, and professional companies. Copies of partnership agreements and operating agreements are required for partnerships and professional companies, respectively.

Copies of articles of incorporation, operating agreements, and partnership agreements should be e-mailed to the Coverage Specialist prior to submitting coverage so that eligibility can be determined. Eligible professional corporations, professional associations, professional companies, and partnerships must be reported on the Form e-216 and submitted along with their applicable worksheets.

1. Calculate the assessment for a professional corporation, association and company or a partnership by computing the sum of 15% of the total 2027 Mcare assessments for each owner, shareholder, member, partner, independent contractor, and employed health care provider (Refer to Example 1). Mid-term endorsements, additions, or deletions for HCPs under the corporation's policy should not be reported as endorsements to the corporation's assessment.

NOTE: ALL OWNERS, SHAREHOLDERS, OR MEMBERS OF A PARTICIPATING PROFESSIONAL CORPORATION, PROFESSIONAL ASSOCIATION, AND PROFESSIONAL COMPANY, AND ALL PARTNERS OF A PARTICIPATING PARTNERSHIP MUST BE HEALTH CARE PROVIDERS AS DEFINED IN ACT 13 OF 2002. WHEN CALCULATING THE ASSESSMENT FOR THE ENTITY, ALL HEALTH CARE PROVIDERS MUST BE INCLUDED REGARDLESS OF QUALIFYING FOR AN EXEMPTION AND NOT DIRECTLY PARTICIPATING IN MCARE.

Example 1

Five health care providers are owners, shareholders, members, partners, independent contractors, or employees of Professional Corporation "Y" which provides emergency room services in Territory 1.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD123456	John Smith	03531	51	$ 13,918	Y3
MD654321	Jane Smith	03531	51	$ 18,558	
MD012345L	Mark Jones	03531	51	$ 18,558	
MD054321E	Sally Jones	03531	51	$ 18,558	
MD246810	Joseph Miller	03531	51	$ 12,063	PT 16

The sum of the total 2027 assessments for all health care providers who are owners, shareholders, members, partners, or employees of Professional Corporation "Y" is $81,655. ($13,918 + $18,558+ $18,558 + $18,558 + $12,063 = $81,655). Thus, the 2027 assessment owed by Professional Corporation "Y" is $12,248 ($81,655 × 15% = $12,248).

If any of the owners, shareholders, members, partners, independent contractors, or employees have different policy dates than the professional corporation, professional association, and professional company, or partnership policy, they shall be listed on the worksheet with their annual 2027 assessment that is effective or will be effective in the same calendar year as the professional corporation, professional association, and professional company or partnership's policy (Refer to Example 2).

Example 2

Professional Corporation "Z" has a policy effective from 7/01/27-7/01/28. The owners, shareholders, members, partners, independent contractors, and employees have individual effective dates as follows:

John Smith	02/01/27-02/01/28	2027 Policy
Jane Smith	07/01/27-07/01/28	2027 Policy
*Mark Jones	11/01/27-11/01/28	2027 Policy

*When Mark Jones renews his 2027 policy on 11/01/27, his assessment will be $18,558. The corporation's assessment is based on his 2027 assessment even though it is not in effect at the time the corporation renews its coverage.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD123456	John Smith	03531	51	$ 13,918	Y3
MD654321	Jane Smith	03531	51	$ 18,558	
MD012345L	Mark Jones	03531	51	$ 18,558	

The sum of the total 2027 assessments for all health care providers who are shareholders, owners, partners, or employees of Professional Corporation "Z" is $51,034. ($13,918 + $18,558 + $18,558 = $51,034). The 2027 assessment owed by Professional Corporation "Z" is $7,655 ($51,034 × 15% = $7,655).

2. Apply other applicable assessment rating factors as outlined in Section IV.

3. Complete the Professional Corporations, Associations and Companies, and Partnerships worksheet (Exhibit 5) and submit with completed Form e-216. List the annual assessment for each HCP on the worksheet. Indicate any discounts applied to an HCP's assessment in the "Other Rating Factors" column.

NOTE: THE HCP'S ANNUAL ASSESSMENT MUST BE LISTED ON THE WORKSHEET EVEN IF REPORTING A SHORT-TERM COVERAGE PERIOD FOR THE HCP BECAUSE THE WORKSHEET WILL PRORATE THE HCP'S ANNUAL ASSESSMENT BASED ON THE DATES PROVIDED.

C. HOSPITALS (SPECIALTY CODE 80612)

REQUIRED FORMS: **EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)**
EXHIBIT 6 (WORKSHEET FOR HOSPITALS)

NOTE: PENNSYLVANIA LAW REQUIRES HOSPITALS TO HAVE FULL ANNUALIZED, SEPARATE, AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A HOSPITAL.

1. Determine all of the territories in which the hospital provides services under the same license. (Refer to Exhibit 11)

2. Calculate the total prevailing primary premium for a hospital by computing:

   a. The sum of the annual occupied bed count (patient days divided by 365 and rounded to the nearest whole number - no partial numbers) for each of the following bed types: Hospital (acute care), Mental Health/Mental Rehabilitation, Extended Care, Outpatient Surgical, and Health Institution, multiplied by the appropriate rate. (Refer to Exhibit 2) Please include an explanation in the body of your submission email when there are year over year changes to bed counts greater than ±20%.

NOTE: WHEN REPORTING THE LIST OF ANNUAL OCCUPIED BED COUNTS ON EXHIBIT 6 FOR THE HOSPITAL, PLEASE DO NOT INCLUDE NURSING HOME BEDS.

PLUS

b. The sum of the annual visit count for each of the following visit types: Emergency, Other, Mental Health/Mental Rehabilitation, Extended Care, Outpatient Surgical, Health Institution, and Home Health Care, divided by 100 and rounded to the nearest **whole** number, then multiplied by the appropriate rate. (Refer to Exhibit 2) Please include an explanation in the body of your submission email when there are year over year changes to visit counts greater than ±20%.

3. Calculate the assessment for a hospital by multiplying the total prevailing primary premium (PPP) (the sum of the annual occupied bed and visit counts) by the Hospital Experience Modification (HEM) Factor (as provided by Mcare), then multiplied by the 2027 annual assessment of 30% (Mcare assessment = PPP × HEM × 30%). See note at bottom of page.

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete Hospital Worksheet (Exhibit 6) for each territory in which the hospital provides services, under the same license, listing the bed and visit counts separately for each territory and submit with completed Form e-216.

NOTE: THE HOSPITAL EXPERIENCE MODIFICATION FACTOR MUST BE ENTERED AS A NUMBER (DECIMAL) AND NOT AS A PERCENTAGE ON THE HOSPITAL WORKSHEET, EXHIBIT 6 (98.9% SHOULD BE ENTERED AS 0.989).

NOTE: THE HOSPITAL WORKSHEET MULTIPLIES THE BED COUNTS BY THE TERRITORY RATE TO REACH THE SUBTOTAL AMOUNT. IT DIVIDES THE VISIT COUNTS BY 100 FIRST, THEN MULTIPLIES BY THE TERRITORY RATE TO REACH THE SUBTOTAL AMOUNT. ALL COUNTS SHOULD BE ENTERED AS AN ANNUAL AMOUNT. ALTHOUGH HOSPITALS' ASSESSMENTS ARE BASED ON A TOTAL OF BEDS AND VISIT COUNTS PER TERRITORY, ASSESSMENTS FOR PHYSICIANS, PODIATRISTS, AND CERTIFIED NURSE MIDWIVES EMPLOYED BY HOSPITALS ARE BASED ON THE HIGHEST RATED TERRITORY IN WHICH THE HEALTH CARE PROVIDER PRACTICES.

The Pennsylvania Department of Health (DOH) has provided guidance related to the following Innovative Hospital Models:

- Micro-hospitals
- Tele-emergency Departments (tele-EDs)
- Outpatient Emergency Departments (OEDs)

The appropriate annual occupied beds and/or visits must be captured in Exhibit 6 (Worksheet for Hospitals) to accurately calculate the Mcare Assessment for hospitals with these models.

Include annual occupied bed and visit counts for **micro-hospitals** the same way as a stand-alone licensed hospital or include them in the counts for a licensed hospital if it is a campus.

Include annual occupied bed and visit counts for **tele-emergency departments (tele-EDs)** in the calculation of the Mcare Assessment for the associated licensed hospital.

Include annual visit counts for **outpatient emergency departments (OEDs)** in the calculation of the Mcare Assessment for the associated licensed hospital.

Failure to contemplate these counts in the assessment calculation may result in the denial of Mcare coverage in the event of a claim against a micro-hospital, tele-ED, or OED.

Please refer to the links under "Resources" on DOH's website linked above for more information pertaining to these models.

D. NURSING HOMES (SPECIALTY CODE 80924)

REQUIRED FORMS: **EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)**
EXHIBIT 7 (WORKSHEET FOR NURSING HOMES)

NOTE: PENNSYLVANIA LAW REQUIRES NURSING HOMES TO HAVE FULL ANNUALIZED, SEPARATE, AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A NURSING HOME.

1. Determine all of the territories in which the nursing home provides services under the same license. (Refer to Exhibit 11)

2. Calculate the total prevailing primary premium by computing the sum of the annual occupied bed count (patient days divided by 365 and rounded to the nearest whole number) for the appropriate bed type: Convalescent or Skilled Nursing, multiplied by the appropriate rate. (Refer to Exhibit 2) Please include an explanation in the body of your submission email when there are year over year changes to bed counts greater than ±20%.

   Each nursing home must report either convalescent bed counts or skilled nursing bed counts, not both. If 50% or more of patients are under age 65, all bed counts must be reported as convalescent. If 50% or more of patients are over age 65, all bed counts must be reported as skilled nursing.

NOTE: WHEN REPORTING THE LIST OF ANNUAL OCCUPIED BED COUNTS ON EXHIBIT 7 FOR THE NURSING HOME, PLEASE DO NOT INCLUDE ANY HOSPITAL BEDS.

3. Calculate the assessment for a nursing home by multiplying the total prevailing primary premium by the 2027 annual assessment of 30%.

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete a Nursing Home Worksheet (Exhibit 7) for each territory in which the nursing home provides services, under the same license, listing the bed counts separately for each territory and submit with completed Form e-216.

E. PRIMARY HEALTH CENTERS (SPECIALTY CODE 80614)

REQUIRED FORMS: **EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)**
EXHIBIT 8 (WORKSHEET FOR PRIMARY HEALTH CENTERS)

NOTE: PENNSYLVANIA LAW REQUIRES PRIMARY HEALTH CENTERS TO HAVE FULL ANNUALIZED, SEPARATE, AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A PRIMARY HEALTH CENTER.

Proof of Mcare eligibility is required for any entity that is newly reported to Mcare. A copy of the entity's Pennsylvania primary health center certificate is required and should be e-mailed to the Coverage Specialist prior to submitting coverage so that eligibility can be determined. To obtain a copy of a primary health center certificate or to apply for certification or recertification as a primary health center, contact the Bureau of Managed Care at 1-888-466-2787 or RA-INBURMNGDCAREPRDR@pa.gov with "PHC Certification" included in the subject line.

1. Determine all of the territories in which the primary health center provides services under the same license. (Refer to Exhibit 11)

2. Calculate the total prevailing primary premium by computing the sum of the annual visit count for each of the following visit types: Emergency, Other, Mental Health/Mental Rehabilitation, Outpatient Surgical, and Home Health Care divided by 100, then multiplied by the appropriate rate. (Refer to Exhibit 2)

3. Calculate the assessment for a primary health center by multiplying the total prevailing primary premium by the 2027 annual assessment of 30%.

4. Apply other applicable assessment rating factors as outlined in Section IV.

5. Complete a Primary Health Center Worksheet (Exhibit 8) for each territory in which the primary health center provides services, under the same license, listing the visit counts separately for each territory and submit with completed Form e-216.

F. BIRTH CENTERS (SPECIALTY CODE 80402)

REQUIRED FORMS: **EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)**
EXHIBIT 9 (WORKSHEET FOR BIRTH CENTERS)

NOTE: PENNSYLVANIA LAW REQUIRES BIRTH CENTERS TO HAVE FULL ANNUALIZED, SEPARATE, AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A BIRTH CENTER.

1. Determine all of the territories in which the birth center provides medical or healthcare services under the same license. (Refer to Exhibit 11)

2. Calculate the assessment by computing the sum of 25% of the total 2027 assessments for all HCPs who use the facility or who have an ownership interest (Refer to Example 3).

Example 3

Three health care providers whose specialty codes are 08029 use or have an ownership interest in Birth Center "X" in territory 1.

License #	Name	Specialty Code	County Code	HCP's Assessment	Other Rating Factors
MD654321	Jane Smith	08029	51	$36,960	
MD054321E	Sally Jones	08029	51	$18,480	PT 08
MD246810	Joseph Miller	08029	51	$36,960	

The sum of the total 2027 assessments for all health care providers who use the facility or who have an ownership interest in Birth Center "X" is $92,400 ($36,960 + $18,480 + $36,960 = $92,400). The 2027 assessment owed by Birth Center "X" is $23,100 ($92,400 × 25% = $23,100).

3. Complete a Birth Center Worksheet (Exhibit 9) for each territory in which the birth center provides services, under the same license and submit with completed Form e-216.

G. SELF-INSURED ENTITIES

REQUIRED FORM: **EXHIBIT 4 (REMITTANCE ADVICE FORM E-216)**

NOTE: PENNSYLVANIA LAW REQUIRES SELF-INSUREDS TO HAVE FULL ANNUALIZED, SEPARATE, AND INDIVIDUAL LIMITS. ADDITIONAL INSUREDS MAY NOT SHARE LIMITS WITH A SELF-INSURED.

- Self-insured entities should follow the same procedures as primary insurers when submitting the Form e-216. All renewals and endorsements to the plan, including additions and deletions, should be received by Mcare within 60 calendar days of the effective date of the renewal, additions, and/or deletions in order to be considered timely.

- The worksheets listed below are also to be used by self-insured entities, when applicable, and must be completed and submitted along with a completed Form e-216.

    - Exhibit 5 (Worksheet for Professional Corporations, Associations and Companies, and Partnerships)
    - Exhibit 6 (Worksheet for Hospitals)
    - Exhibit 7 (Worksheet for Nursing Homes)

H. PHYSICIAN TELEMEDICINE For the purposes of calculating an Mcare assessment, participating HCPs should be rated as if treating patients in person at the patient's geographic treatment location. When two or more specialties or territories are applicable on the primary policy, the highest rated classification and territory should be used when reporting to Mcare.

I. TEMPORARY OR CAMP LICENSES Physicians practicing pursuant to a temporary or camp license must be included on an e-216 submitted to Mcare by the primary insurer/self-insurer/RRG that is providing professional liability coverage for the physician or a Declaration of Compliance that sets forth the appropriate exemption.

NOTE: THE REVIEW TOOL ON FORM E-216 WILL INDICATE AN ERROR WHEN REPORTING TEMPORARY (TMD) OR CAMP (TCP) LICENSES. YOU CAN SKIP THESE ERROR MESSAGES.

SECTION IV - ADDITIONAL ASSESSMENT RATING FACTORS

In addition to the above information, there are other factors that affect the HCP's assessment that are listed below:

A. PART-TIME Physicians, podiatrists, and certified nurse midwives who advise their primary insurer or self-insurer in writing that they practice on annual average:

- "08" 8 hours or less per week shall be charged 50% of the otherwise applicable Mcare assessment (50% discount).
- "16" 16 hours or less, but more than 8 hours per week, shall be charged 65% of the otherwise applicable Mcare assessment (35% discount).
- "24" 24 hours or less, but more than 16 hours per week, shall be charged 80% of the otherwise applicable Mcare assessment (20% discount).

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED WITH AN FTE FACTOR LESS THAN 1.000.

B. NEW PHYSICIANS OR NEW PODIATRISTS Such physicians or podiatrists must be either joining a medical group or opening their own medical practice. These providers may receive the discount indicated from the otherwise applicable assessment:

- "Y1" Charge 25% of the otherwise applicable assessment for the first year of coverage (75% discount).
- "Y2" Charge 50% of the otherwise applicable assessment for the second year of coverage (50% discount).
- "Y3" Charge 75% of the otherwise applicable assessment for the third year of coverage (25% discount).

The first year of coverage for a new physician or a new podiatrist begins on the date medical liability coverage is effective if such coverage is effective within six months after:

1. The completion of (a) a residency program, (b) a fellowship program in their medical specialty, or (c) podiatry school or
2. The fulfillment of a military obligation in remuneration for medical school tuition.

If the initial coverage is effective more than six months after (1) or (2) above first occurs, the physician or podiatrist will be considered to be in the year of coverage that would apply if coverage had been effective within six months after (1) or (2) above. In other words, a new physician or podiatrist cannot have a full year of Y1 unless it is effective within six months of (1) or (2) above (Refer to Example 4).

Example 4

Full year Y1:

- Physician/Podiatrist completes residency 01/01/27. A full year is afforded if coverage is effective anytime between 01/01/27 and 07/01/27. If coverage is effective 03/01/27:
  - Y1: 03/01/27 – 03/01/28 (Policy dates are the same)
  - Y2: 03/01/28 – 03/01/29 (Policy dates are the same)
  - Y3: 03/01/29 – 03/01/30 (Policy dates are the same)

Less than full year Y1:

- Physician/Podiatrist completes residency 01/01/27. Less than a full year is afforded if coverage is effective after 07/01/27. If coverage is effective 09/01/27, report as if Y1 were effective between 01/01/27 and 07/01/27. If using the latest start date of 07/01/27:
  - Y1: 09/01/27 – 07/01/28 (Policy dates are 09/01/27 – 09/01/28)
  - Y2: 07/01/28 – 07/01/29 (Policy dates are 09/01/28 – 09/01/29)
  - Y3: 07/01/29 – 07/01/30 (Policy dates are 09/01/29 – 09/01/30)
  - Changes to the Y-discount should be reported as mid-term endorsements in this scenario.

NOTE: A HEALTH CARE PROVIDER MAY ONLY USE ONE LIFETIME (Y1, Y2, Y3) SERIES OF NEW PHYSICIAN OR NEW PODIATRIST DISCOUNT. THIS DISCOUNT IS NOT AVAILABLE TO CERTIFIED NURSE MIDWIVES.

C. RESIDENTS AND FELLOWS may receive the discount indicated from the otherwise applicable assessment:

- "R" Charge 50% of the otherwise applicable assessment for a Resident (50% Discount).
- "F" Charge 50% of the otherwise applicable assessment for a Fellow (50% Discount).

A resident or fellow is a physician enrolled in a medical or osteopathic residency or fellowship program who has successfully completed the prescribed period of postgraduate education that is necessary under applicable law to become eligible for unrestricted medical, osteopathic, or podiatry licensure in the Commonwealth of Pennsylvania. Podiatrists enrolled in a residency or fellowship programs are eligible for unrestricted podiatry licensure without a prescribed period of postgraduate education. Physicians and podiatrists are only required to participate in Mcare when they become eligible for unrestricted licenses, regardless of whether they apply for the unrestricted license.

NOTE: RESIDENT/FELLOW AND NEW PHYSICIAN DISCOUNTS CANNOT BE USED TOGETHER.

D. SLOT POSITIONS Slot rating is limited to (a) employees of an institution licensed as a hospital, (b) a physician practice plan owned by a hospital or that hospital's corporate parent organization, or (c) an entity where multiple HCPs fill one position in a manner substantially similar to the aforementioned. Slot rating is used to account for certain risks (see notation below) associated with a block of in-hospital clinical medical service exposures (i.e., several physicians rotating through one full-time equivalent position). The slot positions must be within the scope of duties and normal business of the institution and within a single medical specialty and job description. When added together, all HCPs within this one slot or block of exposure must equal one Full-Time Equivalent (FTE); this means that the HCP's combined FTEs must equal 1.000 on the e-216 at renewal.

When multiple HCPs fill a slot-rated position, the assessment shall be appropriately divided among them on a pro rata basis for the FTE position. If the aggregate hours of clinical time of those filling a slot exceed 40 hours per week, a new slot must be created. Each HCP in a slot must be reported to Mcare with full, separate, and individual coverage limits as required by the Mcare Act. Such coverage is available only for the individual professional liability of the HCPs within the slot and is not available for entities. The number of HCPs in any one slot shall be limited to 12.

Slot coverage is not available to HCPs associated with group practices for non-hospital environments or to groups that contract to provide medical services within a hospital. Slot rating is not available to an HCP who works full-time in one specialty (40 hours or more per week) at an institution unless the position is a rotating resident position.

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED IN A SLOT.

The assessment for each HCP in a slot position should be reported at renewal. An HCP that is added to a slot mid-term is considered a non-money transaction when reporting to Mcare and no additional assessment will be imposed for that addition. Similarly, a cancellation for an HCP that leaves a slot position mid-term where the slot position remains open is also a non-money transaction when reported to Mcare and no credit will be issued. For coverage written on a claims made basis, tail coverage must be reported for each departed HCP in a slot position. If a slot position is opened or permanently closed mid-term, please contact your Mcare Coverage Specialist for guidance on reporting.

NOTE: TAIL COVERAGE MUST PROVIDE EACH HEALTH CARE PROVIDER WITH A SEPARATE AND INDIVIDUAL COVERAGE LIMIT.

E. DAILY RATING (FORMERLY LOCUM TENENS) This includes HCPs practicing as locum tenens, per diem, with staffing agencies and other circumstances where the primary insurance coverage is written on a daily basis. Daily rating should only be used if a part-time discount will not accurately capture the amount of time an HCP is providing health care services in Pennsylvania. Before reporting daily coverage, the Mcare Participation requirements in the Introduction of this manual should be reviewed (See pages 3 & 4).

NOTE: EACH HEALTH CARE PROVIDER MUST BE PROVIDED A SEPARATE AND INDIVIDUAL COVERAGE LIMIT.

REPORTING DAILY RATED COVERAGE When reporting daily rated coverage on Form e-216 select "DR" or "LT" in the Policy Modifier column.

Reporting an annualized policy period with a Full-Time Equivalent (FTE) is the preferred method for reporting physicians, certified nurse midwives and podiatrists who have daily rated policies.

Annualized reporting limits the chance of gaps occurring in the HCP's Mcare coverage and lessens the likelihood that Mcare will contact the HCP about missing coverage.

To report an annualized daily rating policy, enter a coverage period on the e-216 that matches the underlying primary insurance coverage term and pay an initial assessment using the FTE that best estimates the number of days the HCP will practice in Pennsylvania during the term. A reasonable estimate can be determined using the number of days the HCP worked in the previous year. To calculate the FTE, divide the number of days to be worked by 365 (365 days should also be used in a leap year). An FTE less than .003 (one day) cannot be used. At the end of the policy term, an endorsement should be submitted to report the actual number of days worked (See page 12 for directions on reporting an endorsement). The FTE Factor column of Form e-216 contains an FTE Calculator. Click the FTE Calculator button to open a calculator that will determine a 1-Day Minimum FTE Factor and an Actual FTE Factor based on the policy dates and days worked.

NOTE: IF THE POLICY TERM IS LESS THAN A YEAR, CALCULATE THE FTE BY DIVIDING THE NUMBER OF DAYS WORKED BY THE NUMBER OF DAYS IN THE POLICY TERM.

Example 5

The policy term being reported is 1/1/27 – 1/1/28. The HCP worked 60 days the previous year, so the estimated FTE would be 0.164 (60 ÷ 365 = 0.164). The HCP has the following assignments in PA for 2027: 2/6/27 - 2/26/27 (20 days), 5/1/27 - 5/27/27 (26 days), 7/1/27 - 7/27/27 (26 days). A total of 72 days of daily rating assignment in PA equals an FTE of 0.197 (72 ÷ 365 = 0.197). An endorsement must be reported changing the estimated FTE of 0.164 to the actual FTE of 0.197.

NOTE: PART-TIME DISCOUNTS ARE NOT AVAILABLE TO HEALTH CARE PROVIDERS REPORTED WITH AN FTE FACTOR LESS THAN 1.000.

ENDING A DAILY RATED POLICY If primary insurance coverage is written on a claims made basis, tail coverage or its substantial equivalent must be obtained and reported to Mcare upon termination of the claims made coverage. The coverage offered must provide for a reporting period of unlimited duration.

F. BIFURCATION (BIFU) If an HCP changes the effective date of their professional liability coverage to attempt to avoid or delay payment of an increase in the annual assessment rate, then the appropriate assessment will be bifurcated to include the assessment percentages applicable to each calendar year over which the new policy is in effect. This allows only 12 months maximum at the same assessment rate for the year that the policy effective date was changed. Reporting a bifurcated assessment is complicated and situation specific. If you believe you have a bifurcation situation, please contact your Mcare Coverage Specialist.

SECTION V - NONPARTICIPATING TRANSMITTAL FORM (Form e-316)

A. GENERAL INFORMATION Form e-316 is a Microsoft Excel Macro-Enabled Worksheet (.xlsm). Macros must be enabled to ensure that the form works as intended. Please keep the file in .xlsm format to preserve functionality. Form e-316 can be downloaded from our website's Coverage page.

B. FORM e-316, Exhibit 10, is the form to be used by primary insurers and self-insurers who provide coverage to nonparticipating HCPs. A nonparticipating HCP that conducts less than 50%, but more than 0% of their health care business or practice within this Commonwealth and does not choose to participate in Mcare. The health care business or practice is based on the number of patients to whom health care services are rendered by an HCP within an annual period.

Nonparticipating HCPs must secure basic insurance coverage limits as required by and consistent with Act 13 of 2002. Current coverage limits are $1 million per occurrence or claim and $3 million per annual aggregate.

C. ELECTRONIC SUBMISSIONS The preferred method for primary insurers and self-insurers submitting coverage to Mcare is to do so electronically via the following e-mail address: ra-in-remittance@pa.gov. This can be done easily by clicking the Submit e-316 button found on the form. Clicking this button will create an email with the appropriate subject line, a brief description of your submission, and a copy of your form attached. A hard copy Nonparticipating Transmittal Form 316 is no longer required when submitting your e-316.

SECTION VI - CLAIMS MADE COVERAGE REQUIREMENTS AND REPORTING

A. GENERAL INFORMATION Following cancellation, termination or nonrenewal of claims made coverage ("end of coverage"), a health care provider is required by Pennsylvania law to provide for claims made after the end of coverage. A primary insurer writing claims made medical professional liability insurance is required by Pennsylvania law to offer such coverage for a period of 60 calendar days after the end of coverage. The coverage offered must provide for a reporting period of unlimited duration and individual limits as defined by Act 13 of 2002.

B. EXTENDED REPORTING COVERAGE Contemporaneous with the end of coverage of a claims made policy, a health care provider must secure coverage for claims that are made against them after the date of policy expiration. Coverage can be obtained from the primary insurer of the expiring policy, often referred to as "tail coverage", or from a new insurer authorized to write medical professional liability insurance in Pennsylvania providing policy retroactive dates that cover the expiring coverage time periods, often referred to as "nose coverage".

C. REPORTING EXTENDED REPORTING COVERAGE GENERALLY Mcare recognizes two types of tail coverage for Mcare reporting and coverage purposes; both types must provide for a reporting period of unlimited duration. Please select from one of the following two options when reporting tail coverage:

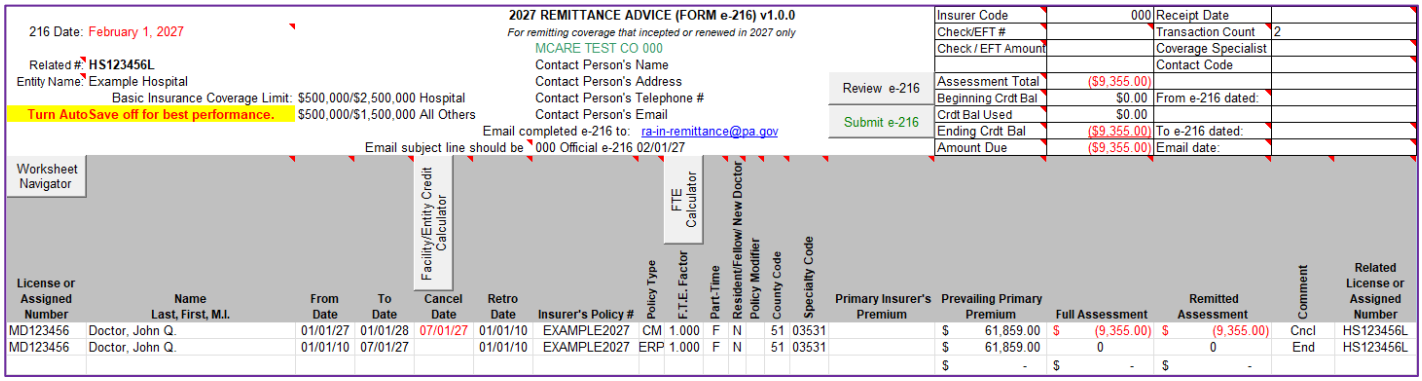
Extended Reporting Period (ERP) – this type of tail coverage shares the aggregate limit of the claims made coverage that is ending.

Stand-Alone (SAT) – this type of tail coverage does not share the aggregate limit of the claims made coverage that is ending. Rather, this type of tail coverage provides the HCP a new aggregate limit.

NOTE: IF THE PRIMARY INSURER ISSUES A TAIL ENDORSEMENT THAT PROVIDES THE HCP A NEW AGGREGATE LIMIT, IT SHOULD BE REPORTED AS STAND-ALONE (SAT) TAIL COVERAGE.

To report tail:

1. Enter the entirety of the HCP's claims made exposure in the From Date and To Date fields; the From Date should match the Retro Date.
2. Enter "ERP" or "SAT" in the Policy Type field.
3. Complete all other applicable coverage information.
4. Enter "End" in the Comment field.



2027 REMITTANCE ADVICE (FORM e-216) v1.0.0
For remitting coverage that incepted or renewed in 2027 only

216 Date: February 1, 2027
Related #: HS123456L
Entity Name: Example Hospital
Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital
Turn AutoSave off for best performance. $500,000/$1,500,000 All Others
MCARE TEST CO 000
Contact Person's Name
Contact Person's Address
Contact Person's Telephone #
Contact Person's Email
Email completed e-216 to: ra-in-remittance@pa.gov
Email subject line should be 000 Official e-216 02/01/27

Review e-216
Submit e-216

Insurer Code	000	Receipt Date	
Check/EFT #		Transaction Count	2
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	($9,355.00)		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	($9,355.00)	To e-216 dated:	
Amount Due	($9,355.00)	Email date:	

Worksheet Navigator | Facility/Entity Credit Calculator | FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
MD123456	Doctor, John Q.	01/01/27	01/01/28	07/01/27	01/01/10	EXAMPLE2027	CM	1.000	F	N	51	03531		$ 61,859.00	$ (9,355.00)	$ (9,355.00)	Cncl	HS123456L
MD123456	Doctor, John Q.	01/01/10	07/01/27		01/01/10	EXAMPLE2027	ERP	1.000	F	N	51	03531		$ 61,859.00	0	0	End	HS123456L
														$ -	$ -	$ -		

John Q. Doctor was cancelled effective 7/01/27.
ERP tail is being reported from 1/01/10-7/01/27 with a retro date of 1/01/10.

D. REPORTING EXTENDED REPORTING COVERAGE WITH A RETROACTIVE DATE PRIOR TO JANUARY 1, 1997 Prior to January 1, 1997, the assessment was based on the cost of the basic insurance coverage and not the prevailing primary premium. Thus, when there was an end of coverage for claims made coverage, a surcharge was paid on the extended reporting coverage. Given the passage of time, claims that would be reported with incident dates prior to January 1, 1997 would not require basic insurer premium and thus Mcare will not require a surcharge for tail coverage with a retroactive date prior to January 1, 1997.

E. INTERIM TAIL (IT) is a code available in the policy type field of the e-216 that was created by Mcare to accommodate insurers who are providing Rolling IBNR. IT is provided in recognition of this underwriting practice and it is to be used when reporting Rolling IBNR coverage to Mcare. IT is not a substitute for an ERP or SAT tail; a tail of unlimited duration must ultimately be reported for any claims made policy, as stated previously in this section. IT is a placeholder, and indicates that the insurer is providing an extended reporting period that will later be reported as ERP or SAT. IT is used in situations where a roster of departed health care providers continues to be covered on a master policy by Rolling IBNR coverage prior to being reported with a tail of unlimited duration.

IT does not provide renewed per occurrence or aggregate Mcare limits. As with ERP, IT shares the aggregate limit remaining of the last reported claims made coverage for that period at the Mcare layer. The insurer may elect to provide refreshed primary limits.

To report Interim Tail:

1. Enter the entirety of the HCP's claims made coverage period in the From Date and To Date fields. The From Date should match the Retro Date and the To Date should match the date that the HCP left the group.
2. Enter "IT" in the Policy Type field.
3. Complete all other applicable coverage information.
4. Enter "End" in the Comment field.
5. Enter a Related Number in the Related License or Assigned Number field.

IT should be reported along with a cancellation when an HCP leaves a master policy mid-term. Differing from ERP and SAT, IT must be reported annually with each policy renewal following an HCP's departure; this indicates to Mcare that the HCP is still covered by Rolling IBNR and that the insurer has not yet issued an ERP or SAT, which provides a tail of unlimited duration.

It is possible for Rolling IBNR exposures to move from one insurer to another. In such circumstances, the new insurer should continue reporting IT annually if a tail of unlimited duration has not yet been obtained. Be advised that the last insurer to report IT coverage will be responsible for providing tail coverage for prior claims made coverage as if it had been reported to Mcare as an unlimited tail.

Please reach out to your assigned Mcare Coverage Specialist to discuss Rolling IBNR coverage and how to report IT coverage.

SECTION VII - DEFINITIONS

When completing the necessary forms and/or worksheets, it is important that you keep the following definitions in mind:

Beds
The number of beds equals the daily average number of occupied beds, cribs, and bassinets used for patients during the previous policy period. The unit of exposure is each bed, computed by dividing the sum of the daily numbers of beds, cribs, and bassinets used for patients for each day of the policy period, by the number of days in such period.

Convalescent Facilities
Convalescent Facilities are free-standing facilities which provide skilled nursing care and treatment for patients requiring continuous health care, but do not provide any hospital services (such as surgery); and 50% or more of their patients are under 65.

Extended Care
All beds located within a hospital, licensed by the state and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous and extended basis.

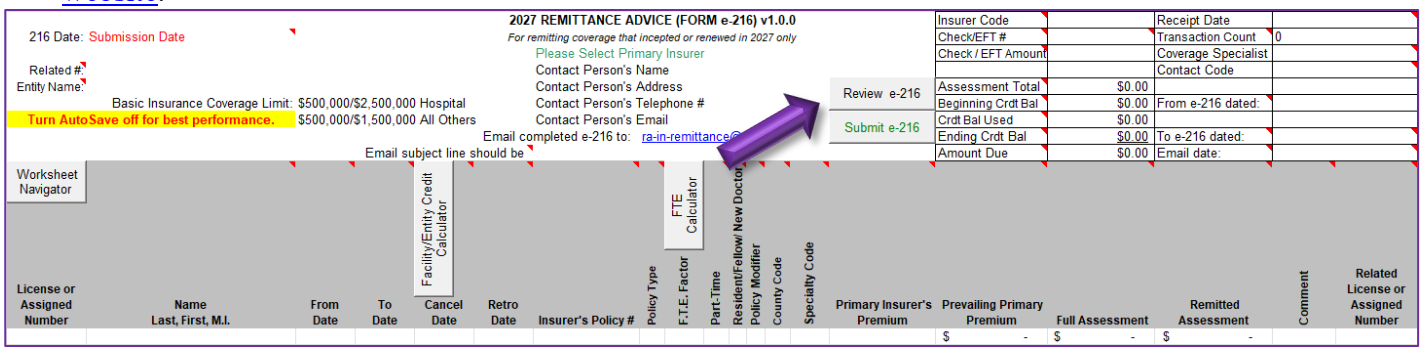
Outpatient Surgical
Outpatient Surgical Facilities are facilities that provide surgical procedures on an outpatient (same day) basis. Beds are used primarily for recovery purposes, and overnight stays, if any, are the exception.

Skilled Nursing Facilities
Skilled Nursing Facilities are free-standing facilities which provide the same service as a Convalescent Facility, except that more of their patients are over 65.

Visits
The number of visits equals the total number of visits to the institution (regardless of the number of visits to particular departments within such institution) by outpatients (patients not receiving bed and board services), during the previous policy period. The unit of exposure is 100 visits each.

SECTION VIII - FORM e-216 REVIEW & CHECKLIST

A. e-216 REVIEW The Review e-216 button can be used to find many common errors in rows 11 and below of the e-216. Please note that the Review e-216 tool is intended to assist with filling out the e-216 and does not guarantee that a submission will be free of errors. More information about the Review e-216 tool can be discovered in the Mcare e-216 Tools Manual which is available alongside the e-216 on Mcare's website.



"Review e-216" button.

B. e-216 CHECKLIST Below are items that should be verified prior to submission of your e-216 to Mcare:

GENERAL

- Are you using the correct e-216 year? The e-216 year should match the year of the primary policy.
- Have you filled in the insurer name, insurer code, and contact information?
- Have you completed the contact information fields using the information of the person who should be contacted in case there are any questions with the e-216?
- If money is due to Mcare, does the e-216 submission have the check, ACH or Wire # in cell Q2 of the e-216?
- Does the e-216 have the check, ACH or Wire amount in cell Q3 of the e-216?
- If you are utilizing a credit, have you completed the credit balance fields on the e-216?
- Have specialties, classes & territories changed from last year?
- Are related license or assigned numbers placed in Cell B4 or Column V?

LICENSE NUMBERS

- Have MT/OT's changed to MD/OS's?
- Are license numbers provided for each health care provider? Visit www.pals.pa.gov to find license numbers for individual health care providers. Visit this manual's section on related license or assigned numbers for instructions on finding a number for a facility or entity.

SLOTS

- At renewal, do the slot FTEs add up to a whole number for each slot position?
- Are you reporting midterm adds to an existing slot position? If so, this is a non-money transaction.
- Are you reporting a slot cancel? Slot cancels are non-money transactions unless the entire slot position is closing.

CORRECTIONS

- A correction is a new transaction, not a revision of an old one. Are you submitting your corrections on a new e-216?
- Have you used Corr in the comment column?

SUPPORT DOCUMENTS

- Have you included all supporting documentation as a separate attachment, such as Articles of Incorporation?
- Have you included all applicable worksheets?

SUBMITTING

- Clicking the Submit e-216 button will verify your e-216 header for completeness and automatically prepare an email. Further information on this tool can be discovered in the Mcare e-216 Tools Manual which is available alongside the e-216 on Mcare's website.
- If you are e-mailing your e-216 to ra-in-remittance@pa.gov manually, have you used the correct subject line?
- If you are sending a payment, it must be sent to Mcare at the same time the e-216 is e-mailed. Mcare's mailing addresses are found on page 4.
- Does the 216 Date in cell B2 match the date you're emailing your e-216 to Mcare?

SECTION IX - CHANGES TO MEDICAL SPECIALTIES/TERRITORIES

A. CHANGES TO A DIFFERENT CLASS FOR 2027:

NONE

B. CHANGES TO TERRITORIES FOR 2027:

NONE

SECTION X - LIST OF EXHIBITS

EXHIBIT #	TITLE	DESCRIPTION	PAGE #
1	**RATES for Physicians, Surgeons, Podiatrists and Certified Nurse Midwives**	Rates by Territory & Classification	31
2	**RATES for Hospitals, Nursing Homes and Primary Health Centers**	Rates by Territory & Exposure Type	32
3	**SPECIALTY CLASSIFICATION CODES for Physicians, Surgeons, and Other Health Care Providers (JUA)**	Lists Specialty Code Descriptions by Classifications	33
4	**REMITTANCE ADVICE FORM (Form e-216)** Electronic form available on our website www.insurance.pa.gov Exhibit 4 – Electronic Remittance Advice Form e-216 Tab "e-216"	Required Form to Report all Coverage and Financial Transactions	41
5	**CORPORATION, ASSOCIATION & COMPANY, & PARTNERSHIP WORKSHEET** Electronic form available on our website www.insurance.pa.gov Exhibit 5 – Electronic Remittance Advice Form e-216 Tab "MC WS"	Rates by Individual Health Care Providers Policy Information	42
6	**HOSPITAL WORKSHEET** Electronic form available on our website www.insurance.pa.gov Exhibit 6 – Electronic Remittance Advice Form e-216 Tab "HS WS"	Rates for Bed and Visit Counts by Exposure Type & Territory	43
7	**NURSING HOME WORKSHEET** Electronic form available on our website www.insurance.pa.gov Exhibit 7 – Electronic Remittance Advice Form e-216 Tab "NC WS"	Rates for Bed Counts by Exposure Type & Territory	44
8	**PRIMARY HEALTH CENTER WORKSHEET** Electronic form available on our website www.insurance.pa.gov Exhibit 8 – Electronic Remittance Advice Form e-216 Tab "PC WS"	Rates for Visit Counts by Exposure Type & Territory	45
9	**BIRTH CENTER WORKSHEET** Electronic form available on our website www.insurance.pa.gov Exhibit 9 – Electronic Remittance Advice Form e-216 Tab "BC WS"	Rates by Individual Health Care Providers Policy Information	46
10	**NONPARTICIPATING TRANSMITTAL FORM (Form e-316)** Electronic form available on our website www.insurance.pa.gov	Form Used by Insurers to Report Coverage Provided to Non-Participating Health Care Providers	47
11	**COUNTY CODE LIST**	Lists all County Codes & Territory Distribution	48

EXHIBIT 1

Year 2027

30%

Physicians, Surgeons, Podiatrists, and Certified Nurse Midwives

Prevailing Primary Premium/ Assessment

Class	Territory 1		Territory 2		Territory 3		Territory 4		Territory 5		Territory 6		Territory 7		Class
	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	PPP	Assess	
005	5,099	1,530	2,774	832	3,248	974	3,995	1,199	4,294	1,288	3,411	1,023	3,995	1,199	005
006	9,985	2,996	4,926	1,478	5,956	1,787	7,581	2,274	8,233	2,470	6,308	1,892	7,476	2,243	006
007	17,800	5,340	8,364	2,509	10,283	3,085	13,318	3,995	14,531	4,359	10,941	3,282	13,318	3,995	007
010	12,837	3,851	6,180	1,854	7,534	2,260	9,675	2,903	10,530	3,159	7,997	2,399	9,675	2,903	010
012	36,966	11,090	16,797	5,039	20,903	6,271	27,385	8,216	29,979	8,994	22,308	6,692	25,721	7,716	012
015	26,404	7,921	12,149	3,645	15,052	4,516	19,632	5,890	21,464	6,439	16,044	4,813	18,765	5,630	015
017	25,843	7,753	11,903	3,571	14,741	4,422	19,221	5,766	21,014	6,304	15,710	4,713	19,050	5,715	017
020	29,941	8,982	13,706	4,112	17,011	5,103	22,228	6,668	24,317	7,295	18,142	5,443	20,732	6,220	020
022	41,496	12,449	18,791	5,637	23,412	7,024	30,712	9,214	33,630	10,089	24,994	7,498	28,217	8,465	022
025	45,086	13,526	20,370	6,111	25,401	7,620	33,345	10,004	34,720	10,416	27,121	8,136	29,403	8,821	025
030	40,988	12,296	18,566	5,570	23,132	6,940	30,337	9,101	33,220	9,966	24,692	7,408	28,766	8,630	030
035	61,859	18,558	27,750	8,325	34,694	10,408	45,658	13,697	49,586	14,876	37,069	11,121	41,153	12,346	035
050	53,689	16,107	24,154	7,246	30,167	9,050	39,661	11,898	43,457	13,037	32,225	9,668	39,082	11,725	050
060	62,598	18,779	28,075	8,423	35,102	10,531	46,199	13,860	50,637	15,191	37,507	11,252	45,985	13,796	060
070	99,150	29,745	44,157	13,247	55,351	16,605	73,028	21,908	80,098	24,029	59,180	17,754	70,211	21,063	070
080	123,201	36,960	54,742	16,423	68,677	20,603	90,684	27,205	99,485	29,846	73,445	22,034	84,102	25,231	080
090	66,237	19,871	29,677	8,903	37,119	11,136	48,871	14,661	53,571	16,071	39,665	11,900	48,871	14,661	090
100	190,424	57,127	84,319	25,296	105,919	31,776	140,024	42,007	153,666	46,100	113,308	33,992	134,469	40,341	100
120	5,990	1,797	3,166	950	3,743	1,123	4,648	1,394	5,011	1,503	3,938	1,181	4,648	1,394	120
130	43,330	12,999	19,597	5,879	24,427	7,328	32,056	9,617	33,266	9,980	26,080	7,824	27,667	8,300	130
900	39,740	11,922	18,018	5,405	22,440	6,732	29,421	8,826	31,765	9,530	23,953	7,186	26,429	7,929	900

Certified Nurse Midwife = 900 80116
Podiatrist Non-surgical = 120 80993
Podiatrist Surgical = 130 80994

Territory 1= Philadelphia (51)
Territory 2= Reminder of State (01, 05, 06, 08, 10-12, 14, 16, 18, 21, 24, 27-32, 34, 36, 38, 41, 42, 44, 47, 49, 50, 52, 53, 55-62, 64, 66, 67)
Territory 3= Allegheny (02), Armstrong (03), Beaver (04), Carbon (13), Clearfield (17), Dauphin (22), Jefferson (33), Washington (63)
Territory 4= Delaware (23), Fayette (26), Luzerne (40), Mercer (43)
Territory 5= Lackawanna (35)
Territory 6= Bucks (09), Chester (15), Columbia (19), Crawford (20), Erie (25), Lawrence (37), Lehigh (39), Monroe (45), Montgomery (46), Northampton (48), Schuylkill (54), Westmoreland (65)
Territory 7= Blair (07)

Exhibit List

EXHIBIT 2

Year 2027 Prevailing Primary Premiums
Rates for Hospitals, Nursing Homes and Primary Health Centers

Exposure Base	Exposure Type	Rate	Rate	Rate	Rate
		Territory			
	HOSPITALS	1	2	3	4
Per Occ Bed	Hospital (Acute Care)	9,133.63	4,055.32	5,078.29	8,119.81
Per Occ Bed	Mental Health/Mental Rehabilitation	4,570.73	2,029.42	2,541.32	4,063.37
Per Occ Bed	Extended Care	406.62	180.54	226.09	361.48
Per Occ Bed	Outpatient Surgical	9,133.63	4,055.32	5,078.29	8,119.81
Per Occ Bed	Health Institution	1,829.87	812.44	1,017.41	1,626.73
Per 100 Visits	Emergency	912.99	405.38	507.62	811.65
Per 100 Visits	Other	365.18	162.15	203.06	324.66
Per 100 Visits	Mental Health/Mental Rehabilitation	228.27	101.34	126.88	202.89
Per 100 Visits	Extended Care	20.26	9.01	11.25	18.04
Per 100 Visits	Outpatient Surgical	912.99	405.38	507.62	811.65
Per 100 Visits	Health Institution	136.93	60.81	76.15	121.74
Per 100 Visits	Home Health Care	228.27	101.34	126.88	202.89
	NURSING HOMES				
Per Occupied Bed	Convalescent	621.06	275.78	345.34	552.14
Per Occupied Bed	Skilled Nursing	511.49	227.11	284.38	454.73
	PRIMARY HEALTH CENTERS				
Per 100 Visits	Emergency	898.40	398.87	499.51	798.67
Per 100 Visits	Other	359.36	159.54	199.81	319.48
Per 100 Visits	Mental Health/Mental Rehabilitation	224.63	99.75	124.90	199.70
Per 100 Visits	Outpatient Surgical	898.40	398.87	499.51	798.66
Per 100 Visits	Home Health Care	224.63	99.75	124.90	199.70

Territory 1: Delaware (23), Philadelphia (51)
Territory 2: Remainder of State
Territory 3: Allegheny (02), Crawford (20), Erie (25), Lackawanna (35), Lawrence (37), Luzerne (40), Mercer (43)
Territory 4: Bucks (09), Chester (15), Montgomery (46)

EXHIBIT 3

SPECIALTY CLASSIFICATION CODES FOR PHYSICIANS, SURGEONS AND OTHER HEALTH CARE PROVIDERS (JUA)

CLASS 005 PHYSICIANS -NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00534	Administrative Medicine – No Surgery
00508	Hematology – No Surgery
00582	Pharmacology – Clinical
00537	Physicians – Practice limited to Acupuncture (other than acupuncture anesthesia)
00556	Utilization Review
00599	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 006 PHYSICIANS -NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00689	Aerospace Medicine
00602	Allergy/Immunology – No Surgery
00674	Geriatrics – No Surgery
00688	Independent Medical Examiner
00609	Industrial/Occupational Medicine – No Surgery
00687	Laryngology – No Surgery
00649	Nuclear Medicine – No Surgery
00685	Nutrition
00624	Occupational Medicine – Including MRO or Employment Physicals
00612	Ophthalmology – No Surgery
00613	Orthopedics – No Surgery
00665	Otolaryngology or Otorhinolaryngology – No Surgery
00684	Otology – No Surgery
00617	Preventive Medicine – No Surgery
00618	Proctology – No Surgery
00619	Psychiatry – No Surgery, including Psychoanalysts who treat physical ailments, perform electro-convulsive procedures or employ extensive drug therapy.

(Class 006 continues on next page)

00650	Psychoanalysts who do not treat physical ailments, do not perform electro-convulsive procedures and whose use of medication is minimal in order to support the analytic treatment and is never the primary or sole form of treatment shall be eligible for this classification. Except, practitioners of this medical specialty are ineligible for this classification if 25% or more of their patients receive medication.
00621	Rehabilitation/Physiatry – No Surgery
00645	Rheumatology – No Surgery
00681	Rhinology – No Surgery
00623	Urology – No Surgery
00699	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 007 PHYSICIANS -NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
00737	Endocrinology – No Surgery
00758	Hematology/Oncology – No Surgery
00786	Neoplastic Diseases – No Surgery
00741	Nephrology – No Surgery
00743	Oncology – No Surgery
00715	Pathology – No Surgery
00799	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 010 PHYSICIANS -NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01035	Bariatrics – No Surgery
01004	Dermatology – Excluding Major Surgery
01007	Gynecology – No Surgery
01067	Pediatrics – No Surgery
01098	Physicians – Practice limited to Hair Transplants (Plug or Flap Technique or Split Mini Grafts)
01089	Psychosomatic Medicine
01020	Public Health – No Surgery
01059	Radiation Oncology excluding Deep Radiation – No Surgery
01088	Reproductive Endocrinology – No Surgery – No Obstetrical Delivery
01005	Sports Medicine – No Surgery
01099	Physicians Not Otherwise Classified – No Surgery (NOC)

Exhibit List

CLASS 012 PHYSICIANS -NO SURGERY

This classification generally applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01206	Gastroenterology – No Surgery
01253	Radiology excluding Deep Radiation – No Surgery
01299	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 015 PHYSICIANS -NO SURGERY

This classification applies to specialists hereafter listed who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia), who do not assist in surgical procedures, and who do not perform any of the procedures determined to be extra-hazardous by the Association.

JUA CODES	SPECIALTY DESCRIPTION
01582	Anesthesiology – Pain Management only – No Surgery
01520	General or Family Practice – No Surgery
01522	Hospitalist – No Surgery
01540	Infectious Diseases – No Surgery
01589	Intensive Care Medicine
01510	Internal Medicine – No Surgery
01541	Neonatology – No Surgery
01545	Pulmonary Medicine – No Surgery
01559	Radiation Oncology including Deep Radiation – No Surgery
01599	Physicians Not Otherwise Classified – No Surgery (NOC)

CLASS 017 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA Codes	Specialty Description
01755	Ophthalmology – Surgery
01799	Physicians Not Otherwise Classified – Excluding Major Surgery (NOC)

CLASS 020 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02002	Allergy – Excluding Major Surgery
02083	Anesthesiology – Other than Pain Management only – Excluding Major Surgery
02022	Cardiology – No Surgery or Excluding Major Surgery – No Catheterization other than Swan-Ganz
02037	Endocrinology – Excluding Major Surgery
02038	Geriatrics – Excluding Major Surgery
02007	Gynecology – Excluding Major Surgery
02008	Hematology – Excluding Major Surgery
02009	Industrial Medicine – Excluding Major Surgery
02089	Neoplastic Diseases – Excluding Major Surgery
02042	Nephrology – Excluding Major Surgery
02049	Nuclear Medicine – Excluding Major Surgery
02028	Obstetrics – Excluding Major Surgery
02029	Obstetrics/Gynecology, No Obstetrical Delivery – Excluding Major Surgery
02043	Oncology – Excluding Major Surgery
02013	Orthopedics – Excluding Major Surgery
02065	Otolaryngology/Otorhinolaryngology – Excluding Major Surgery
02087	Otology – Excluding Major Surgery
02015	Pathology – Excluding Major Surgery
02016	Pediatrics – Excluding Major Surgery
02017	Preventive Medicine – Excluding Major Surgery
02018	Proctology – Excluding Major Surgery
02019	Psychiatry – Excluding Major Surgery
02020	Public Health – Excluding Major Surgery
02044	Pulmonary Medicine – Excluding Major Surgery
02069	Pulmonary Medicine – No Surgery except Bronchoscopy
02053	Radiology including Deep Radiation – No Surgery
02021	Rehabilitation/Physiatry – Excluding Major Surgery
02086	Reproductive Endocrinology – Excluding Major Surgery – No Obstetrical Delivery
02085	Rhinology – Excluding Major Surgery
02023	Urology – Excluding Major Surgery
02068	Wound Care Physician – Excluding Major Surgery
02099	Physicians Not Otherwise Classified – Excluding Major Surgery (NOC)

CLASS 022 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02223	Cardiology – Including Right Heart or Left Heart Catheterization
02206	Gastroenterology – Excluding Major Surgery
02221	General or Family Practice – Excluding Major Surgery
02210	Internal Medicine – Excluding Major Surgery
02259	Radiation Oncology – Excluding Major Surgery
02260	Radiology including interventional radiology – Excluding Major Surgery
02299	Physicians Not Otherwise Classified (NOC)

CLASS 025 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed who perform minor surgery; who perform extra-hazardous medical techniques as determined by the Association; or who assist in major surgery on their own patients.

JUA CODES	SPECIALTY DESCRIPTION
02540	Infectious Diseases – Excluding Major Surgery
02511	Neurology – Excluding Major Surgery
02599	Physicians Not Otherwise Classified – Excluding Major Surgery (NOC)

CLASS 030 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed; and to other specialists who assist in major surgery on other than their own patients; who perform normal obstetrical deliveries; or who perform extra-hazardous medical techniques as determined by the Association.

JUA CODES	SPECIALTY DESCRIPTION
03017	General or Family Practice – Assist in Major Surgery on other than their own patients or performing normal obstetrical deliveries
03007*	Gynecology – Assist in Major Surgery on other than their own patients
03010	Internal Medicine – Assist in Major Surgery on other than their own patients
03029	Obstetrics/Gynecology, Assist in Major Surgery on other than their own patients-No obstetrical delivery
03043	Oncology – Including Major Surgery
03018	Proctology – Major Surgery
03045	Urological Surgery
03099	Surgeons Not Otherwise Classified (NOC)

*Obstetrical delivery is rated as Class 08029

Exhibit List

CLASS 035 PHYSICIANS - SURGEONS-SPECIALISTS

This classification generally applies to Urgent Care physicians and other specialists who work in an urgent care environment more than eight (8) hours per week; physicians who work in a prison environment more than eight (8) hours per week; or to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
03591	Laryngology – Including Major Surgery
03590	Otology – Including Major Surgery
03565	Otorhinolaryngology or Otolaryngology – Including Major Surgery
03586	Prison Physicians – Excluding Major Surgery
03570	Rhinology – Including Major Surgery
03531	Urgent Care including Emergency Medicine, Fast Track, and similar services – Excluding Major Surgery
03599	Physicians Not Otherwise Classified (NOC)

CLASS 050 SURGEONS -SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
05015	Colon-Rectal Surgery if 75% or more of total surgical practice
05004	Dermatology – Major Surgery (including such plastic and cosmetic surgery that is consistent with the Dermatology medical specialty)
05007	Gynecology – Major Surgery
05089	Reproductive Endocrinology – Major Surgery – No Obstetrical Delivery
05099	Surgeons Not Otherwise Classified (NOC)

CLASS 060 SURGEONS-SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
06047	Colon-Rectal Surgery when 26% or more of the physician's surgical practice is for non colon-rectal surgery
06030	Plastic Surgery
06099	Surgeons Not Otherwise Classified (NOC)

CLASS 070 SURGEONS -SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
07089	Abdominal – Major Surgery
07003	Cardiac Surgery
07053	Cardio-Thoracic Surgery
07046	Cardiovascular Surgery
07048	Cardio-Vascular-Thoracic Surgery
07088	Endocrinology – Major Surgery
07087	Gastroenterology – Major Surgery
07017	General or Family Practice – Major Surgery
07001	General Practice – Major Surgery
07043	General Surgery and Internal Medicine – Major Surgery
07086	Geriatrics – Major Surgery
07025	Thoracic Surgery
07084	Trauma – Major Surgery
07054	Vascular and Thoracic Surgery
07099	Surgeons Not Otherwise Classified (NOC)

CLASS 080 SURGEONS -SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
08001	General Practice – Major Surgery
08028	Obstetrics – Major Surgery
08029	Obstetrics/Gynecology, Full Range of Procedures
08089	Perinatology, including C-Sections, Amniocentesis and Episiotomies
08087	Reproductive Endocrinology – Major Surgery – Including Obstetrical Delivery
08099	Surgeons Not Otherwise Classified (NOC)

CLASS 090 SURGEONS -SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
09013	Orthopedic Surgery
09085	Peripheral Vascular Surgery
09026	Vascular Surgery
09099	Surgeons Not Otherwise Classified (NOC)

CLASS 100 SURGEONS -SPECIALISTS

This classification generally applies to specialists hereafter listed.

JUA CODES	SPECIALTY DESCRIPTION
10011	Neurosurgery
10099	Surgeons Not Otherwise Classified (NOC)

CLASS 120 PODIATRISTS - NON-SURGICAL

JUA CODES	SPECIALTY DESCRIPTION
80993	Podiatry – No Surgery

CLASS 130 PODIATRISTS - SURGICAL

JUA CODES	SPECIALTY DESCRIPTION
80994	Podiatry - Surgery

CLASS 900 CERTIFIED NURSE MIDWIVES

JUA CODES	SPECIALTY DESCRIPTION
80116	Certified Nurse Midwife (CNM)

ADDITIONAL SPECIALTY CODES

MCARE CODES	SPECIALTY DESCRIPTION
80402	Birth Centers
80999	Corporate/Association/Partnership Liability
80612	Hospitals
80924	Nursing Homes
80614	Primary Health Centers

EXHIBIT 4
REMITTANCE ADVICE FORM (Form e-216)

2027 REMITTANCE ADVICE (FORM e-216) v1.0.0

For remitting coverage that incepted or renewed in 2027 only

216 Date: Submission Date

Related #:

Entity Name:

Basic Insurance Coverage Limit: $500,000/$2,500,000 Hospital

Turn AutoSave off for best performance. $500,000/$1,500,000 All Others

Please Select Primary Insurer

Contact Person's Name

Contact Person's Address

Contact Person's Telephone #

Contact Person's Email

Email completed e-216 to: ra-in-remittance@pa.gov

Email subject line should be

Review e-216

Submit e-216

Insurer Code		Receipt Date	
Check/EFT #		Transaction Count	0
Check / EFT Amount		Coverage Specialist	
		Contact Code	
Assessment Total	$0.00		
Beginning Crdt Bal	$0.00	From e-216 dated:	
Crdt Bal Used	$0.00		
Ending Crdt Bal	$0.00	To e-216 dated:	
Amount Due	$0.00	Email date:	

Worksheet Navigator

Facility/Entity Credit Calculator

FTE Calculator

License or Assigned Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Retro Date	Insurer's Policy #	Policy Type	F.T.E. Factor	Part-Time	Resident/Fellow/ New Doctor	Policy Modifier	County Code	Specialty Code	Primary Insurer's Premium	Prevailing Primary Premium	Full Assessment	Remitted Assessment	Comment	Related License or Assigned Number
															$ -	$ -	$ -		
															$ -	$ -	$ -		
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Exhibit 4 Explanation

Exhibit List

EXHIBIT 5
CORPORATION, ASSOCIATION & COMPANY, & PARTNERSHIP WORKSHEET

2027 EXHIBIT 5 - CORPORATION, ASSOCIATION & COMPANY, & PARTNERSHIP WORKSHEET
(SPECIALTY CODE 80999)

Primary Insurer	
Insurer Code	
Date	
Entity's Name	
Entity's Address	
Entity's Assigned #	

Transfer to e-216

Clear Worksheet

Basic Insurance Coverage Limits: $ 500,000.00 Per Occ.
$1,500,000.00 Per Agg.

Entry Worksheets must be transferred to the e-216 by clicking the "Transfer to e-216" button.

From Date	To Date	Retro Date	Policy #	Policy Type	County Code	Mcare Assessment
						$0.00

List all shareholders, owners, partners and employed health care providers

License #	Name	Specialty Code	County Code	HCP's Annual Assessment	Other Rating Factors

Exhibit 5 Explanation

Exhibit List

EXHIBIT 6
HOSPITAL WORKSHEET

2027 EXHIBIT 6 - HOSPITAL WORKSHEET (SPECIALTY CODE 80612)

Primary Insurer	
Insurer Code	
Date	
Hospital's Name	
Hospital's Address	
Hospital's Assigned #	

Transfer to e-216

Clear Worksheet

Basic Insurance Coverage Limits: $ 500,000.00 Per Occ.
$2,500,000.00 Per Agg.

Entry Worksheets must be transferred to the e-216 by clicking the "Transfer to e-216" button.

From Date	To Date	Retro Date	Policy #	Policy Type	County	Territory
						0

List of Annual Occupied Bed Counts

Exposure Type:	Bed Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Hospital (acute care)		0	0	0	0	$ -
Mental Health/Mental Rehab.		0	0	0	0	$ -
Extended Care		0	0	0	0	$ -
Out-Patient Surgical		0	0	0	0	$ -
Health Institution		0	0	0	0	$ -

List of Annual Visit Counts

Exposure Type:	Total Visit Count*	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Emergency		0	0	0	0	$ -
Other		0	0	0	0	$ -
Mental Health/Mental Rehab.		0	0	0	0	$ -
Extended Care		0	0	0	0	$ -
Out-Patient Surgical		0	0	0	0	$ -
Health Institution		0	0	0	0	$ -
Home Health Care		0	0	0	0	$ -

* Enter the actual "Visit Count." The spreadsheet will divide the "Visit Count" entered by 100.

Hospital's Assessment

Prevailing Primary Premium	$0.00
Experience Modification Factor (as provided by Mcare)	
2027 Mcare Assessment %	30%
Mcare Assessment	**$0.00**

Exhibit 6 Explanation
See Exhibit 2 for Rates
Exhibit List

EXHIBIT 7
NURSING HOME WORKSHEET

2027 EXHIBIT 7 - NURSING HOME WORKSHEET (SPECIALTY CODE 80924)

Primary Insurer	
Insurer Code	
Date	
Nursing Home Name	
Nurs. Home's Address	
Nurs. Home's Assigned #	

Transfer to e-216

Clear Worksheet

Basic Insurance Coverage Limits: $ 500,000.00 Per Occ.
$1,500,000.00 Per Agg.

Entry Worksheets must be transferred to the e-216 by clicking the "Transfer to e-216" button.

From Date	To Date	Retro Date	Policy #	Policy Type	County Code	Territory
						0

List Annual Occupied Bed Counts

Exposure Type	Bed Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Prevailing Primary Premium
Convalescent		0	0	0	0	$ -
or						
Skilled Nursing		0	0	0	0	$ -

Nursing Home's Assessment

Prevailing Primary Premium	$ -
Mcare Assessment	**$0.00**

[Exhibit 7 Explanation]
[See Exhibit 2 for Rates]
[Exhibit List]

EXHIBIT 8
PRIMARY HEALTH CENTER WORKSHEET

2027 EXHIBIT 8 - PRIMARY HEALTH CENTER WORKSHEET (SPECIALTY CODE 80614)

Primary Insurer	
Insurer Code	
Date	
PHC's Name	
PHC's Address	
PHC's Assigned #	

Transfer to e-216

Clear Worksheet

Basic Insurance Coverage Limits: $ 500,000.00 Per Occ.
$1,500,000.00 Per Agg.

Entry Worksheets must be transferred to the e-216 by clicking the "Transfer to e-216" button.

From Date	To Date	Retro Date	Policy #	Policy Type	County Code	Territory
						0

List Annual Visit Counts

Exposure Type	Total Visit Count	Terr. 1 Rates	Terr. 2 Rates	Terr. 3 Rates	Terr. 4 Rates	Subtotal
Emergency		0	0	0	0	$0.00
Other		0	0	0	0	$0.00
Mental Health/Mental Rehab.		0	0	0	0	$0.00
Out-Patient Surgical		0	0	0	0	$0.00
Home Health Care		0	0	0	0	$0.00

Primary Health Center's Assessment

Prevailing Primary Premium	$0.00
Mcare Assessment	**$0.00**

Exhibit 8 Explanation
See Exhibit 2 for Rates
Exhibit List

EXHIBIT 9
BIRTH CENTER WORKSHEET

2027 EXHIBIT 9 - BIRTH CENTER WORKSHEET (SPECIALTY CODE 80402)

Primary Insurer	
Insurer Code	
Date	
Birth Center's Name	
Birth Center's Address	
Birth Ctr's Assigned #	

Transfer to e-216

Clear Worksheet

Basic Insurance Coverage Limits: $ 500,000.00 Per Occ.
$1,500,000.00 Per Agg.

Entry Worksheets must be transferred to the e-216 by clicking the "Transfer to e-216" button.

From Date	To Date	Retro Date	Policy #	Policy Type	County Code	Mcare Assessment
						$0.00

List all shareholders, owners, partners and employed health care providers

License #	Name	County Code	Specialty Code	HCP's Annual Assessment	Other Rating Factors

Exhibit 9 Explanation
Exhibit List

EXHIBIT 10
NONPARTICIPATING TRANSMITTAL FORM (Form e-316)

Nonparticipating Transmittal Form (Form e-316) v1.0.42

Form e-316 should only be submitted by primary insurers, brokers, or agents

Proof of insurance for health care providers practicing less than 50% but more than 0% in PA and choosing not to participate in Mcare

Primary Insurer	Please Select Primary Insurer
Insurer Code	
Date	Submission Date
Contact Person's Name	
Contact Person's Address	
Contact Person's Telephone #	
Contact Person's Email	

Submit e-316

Limits: $1,000,000 per occurrence/$3,000,000 per annual aggregate

License Number	Name Last, First, M.I.	From Date	To Date	Cancel Date	Insurer's Policy #

Exhibit 10 Explanation
Exhibit List

EXHIBIT 11
COUNTY CODE LIST

01 Adams	24 Elk	47 Montour
02 Allegheny	25 Erie	48 Northampton
03 Armstrong	26 Fayette	49 Northumberland
04 Beaver	27 Forest	50 Perry
05 Bedford	28 Franklin	51 Philadelphia
06 Berks	29 Fulton	52 Pike
07 Blair	30 Greene	53 Potter
08 Bradford	31 Huntingdon	54 Schuylkill
09 Bucks	32 Indiana	55 Snyder
10 Butler	33 Jefferson	56 Somerset
11 Cambria	34 Juniata	57 Sullivan
12 Cameron	35 Lackawanna	58 Susquehanna
13 Carbon	36 Lancaster	59 Tioga
14 Centre	37 Lawrence	60 Union
15 Chester	38 Lebanon	61 Venango
16 Clarion	39 Lehigh	62 Warren
17 Clearfield	40 Luzerne	63 Washington
18 Clinton	41 Lycoming	64 Wayne
19 Columbia	42 McKean	65 Westmoreland
20 Crawford	43 Mercer	66 Wyoming
21 Cumberland	44 Mifflin	67 York
22 Dauphin	45 Monroe	
23 Delaware	46 Montgomery	

TERRITORY DISTRIBUTION:

For Hospitals, Nursing Homes, and Primary Health Centers:

Territory 1: Delaware (23), Philadelphia (51)
Territory 2: Remainder of State (01, 03-08, 10-14, 16-19, 21-22, 24, 26-34, 36, 38-39, 41-42, 44-45, 47-50, 52-67)
Territory 3: Allegheny (02), Crawford (20), Erie (25), Lackawanna (35), Lawrence (37), Luzerne (40), Mercer (43)
Territory 4: Bucks (09), Chester (15), Montgomery (46)

For All Other Health Care Providers:

Territory 1: Philadelphia (51)
Territory 2: Remainder of State (01, 05, 06, 08, 10-12, 14, 16, 18, 21, 24, 27-32, 34, 36, 38, 41, 42, 44, 47, 49, 50, 52, 53, 55-62, 64, 66, 67)
Territory 3: Allegheny (02), Armstrong (03), Beaver (04), Carbon (13), Clearfield (17), Dauphin (22), Jefferson (33), Washington (63)
Territory 4: Delaware (23), Fayette (26), Luzerne (40), Mercer (43)
Territory 5: Lackawanna (35)
Territory 6: Bucks (09), Chester (15), Columbia (19), Crawford (20), Erie (25), Lawrence (37), Lehigh (39), Monroe (45), Montgomery (46), Northampton (48), Schuylkill (54), Westmoreland (65)
Territory 7: Blair (07)

Exhibit List