COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES
PHYSICIANS SERVICES FOR INDIGENTS PROGRAM (PSIP) DEMOGRAPHIC DATA FORM

PATIENT INFORMATION

COMPLETE ENTIRE FORM AND SUBMIT WITH CMS 1500

1. TPS# (trauma patients only) [ ]

2. Social Security Number [ ][ ][ ][ ][ ][ ][ ][ ][ ]

3. Patient Name ______________________________

Last   First   Middle Initial

PHYSICIAN SERVICES

4. PHYSICIAN FUND

[ ] (1) Contract Trauma

[ ] (2) Non-Contract Emergency

Check either box below

5. SERVICE SETTING

[ ] Inpatient (patient was admitted to a bed)

OR

[ ] Emergency Department only

Also check this box if service was provided by an anesthesiologist

[ ] Anesthesia

6. Physician's Name ____________________ State License # ____________

7. Payee Name ____________________ Payee Tax ID # ____________

Payee Address ______________________________

8. Date Billed County (e.g. 01/31/16) [ ][ ][ ] Charges $

mm dd yy

FOR QUESTIONS REGARDING THIS CLAIM

9. Contact Person ____________________ Telephone # ____________