COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAM

PROGRAM ENROLLMENT PROVIDER FORM
JULY 1, 2016 TO JUNE 30, 2019

Completion of Enrollment Form is required by each physician

Physician Name: _____
(Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____)_____ Contact Person: _____

E-mail Address: _____ NPI #: _____

Primary Specialty: _____ State License Number: _____ **(attach a copy/proof of current licensure)**

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: ( ) _____ Contact Person: _____

LIST ALL HOSPITAL WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents Program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

_____ _____
SIGNATURE OF PHYSICIAN DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:

AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 17908
Los Angeles, CA 90017-0908