

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR
SUBMISSION OF CLAIMS AND DEMOGRAPHIC DATA FORM

JULY 1, 2016 TO JUNE 30, 2019



GENERAL INFORMATION

Physicians must submit both a **CMS-1500 Form** and a **Physician Services for Indigents Program (PSIP) Demographic Data Form** for each patient's care if they are claiming reimbursement under the County's PSIP. Information from both the PSIP Demographic Data Form and the CMS-1500 Form are used by the County to comply with State reporting mandates. **An original PSIP Demographic Data Form must be completed for each patient. Xeroxed documents/information will be rejected.**

PATIENT INFORMATION: Physicians are required to make reasonable efforts to collect all data elements; however, physicians are only required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. If, after reasonable efforts are made, some data elements cannot be obtained, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients as INPATIENT or EMERGENCY DEPARTMENT VISIT will not be accepted without completion of all data elements unless a reasonable justification is provided.**

ALL CLAIMS should be submitted to American Insurance Administrators.

TRAUMA PHYSICIANS - SUBMIT CLAIMS:

American Insurance Administrators (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908
Attention: **TRAUMA CLAIMS**

ALL OTHER PHYSICIANS--SUBMIT CLAIMS TO:

American Insurance Administrators (AIA)
P.O. BOX 17908
Los Angeles, CA 90017-0908
Attention: **PHYSICIAN INDIGENT PROGRAM CLAIMS**

Contact: AIA Physician Hotline - (800) 303-5242 Ext. 518

COMPLETION OF PSIP DEMOGRAPHIC DATA FORM

PATIENT INFORMATION (Items 1-3)

1. **TPS NUMBER**

Enter Trauma Patient Summary number if claim is for a contract trauma patient. If claim is for a non-trauma patient, leave box blank.

2. **SOCIAL SECURITY NUMBER**

Enter Patient's social security number. Failure to provide the social security number must be justified in item # 26 (REASON) of the PSIP Demographic Data Form.

3. **PATIENT'S NAME**

Enter Patient's last name, first name, and middle initial. (1) If Patient is a minor, parent/guardian name must be provided.

PHYSICIAN SERVICES (Items 4-9)

4. **PHYSICIAN FUND**

Check appropriate box to indicate type of claim being submitted:

(1) **CONTRACT TRAUMA** - trauma care provided at the following hospitals:

Antelope Valley Hospital
California Hospital Medical Center
Cedars-Sinai Medical Center
Childrens Hospital Los Angeles
Henry Mayo Newhall Memorial Hospital
Holy Cross Medical Center
Huntington Memorial Hospital
Memorial Hospital Medical Center of Long Beach
Northridge Hospital Medical Center
St. Francis Medical Center
St. Mary Medical Center
UCLA Medical Center
Other hospitals as approved by the Board of Supervisors and designated by the Emergency Medical Services Agency

(2) **NON-CONTRACT
EMERGENCY**

- all emergency services provided by a licensed Physician excluding specialty trauma care provided by a designated contract trauma hospital as per (1) above.

5. **SERVICE SETTING**

Check one of the following:

- (1) Inpatient
- (2) Emergency Department

Also check the Anesthesia box if service was provided by an anesthesiologist

6. **PHYSICIAN'S NAME AND STATE LICENSE NUMBER**

Enter Physician's name and State license number.

7. **PAYEE NAME, ADDRESS AND TAX ID NUMBER**

Enter payee name, address, and nine (9) digit federal tax ID number.

8. **DATE BILLED COUNTY**

Enter date Physician billed the County.

CHARGES

Enter total amount of Physician charges.

9. **CONTACT PERSON/TELEPHONE NO.**

Enter name and telephone number of individual authorized to answer questions regarding the claim.

COMPLETION OF CMS-1500 FORM

The following CMS-1500 items must be completed:

Patient's Name (last, first, middle initial)

Patient's Date of Birth and Sex

Patient's Address (city, state, zip)

Employment Information

Hospitalization Dates Related to Current Services (Admission and Discharge dates)

***** Note:** Hospital admit and discharge dates that are equal (i.e., 07-01-06 to 07-01-06) in box 18 must have an explanation in box 19 (Reserved for Local Use)

Diagnoses (primary and two others)

Date of Service

Procedures (descriptions)

Patient's Account No.

Name and Address of Facility Where Services Were Rendered

The CMS-1500 section at the top of the form indicating *Medicare, Medicaid, Champus, Group Health Plan, Other*, will only be accepted when *Other* is checked or the section is left blank. If any other box is checked (*Medicare, Medicaid, Group Health Plan, etc.*), the claim will be rejected.

When completing Section Number 24 (A thru K) all lines are to be utilized before going on to another CMS-1500 form.