COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CLAIMS AND DEMOGRAPHIC DATA FORM

JULY 1, 2022 TO JUNE 30, 2025

GENERAL INFORMATION

Physicians must submit an original copy of the **CMS-1500 Form** and the **Physician Services for Indigents Program (PSIP) Demographic Data Form** for each patient's care if they claim 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. **Originals of both the CMS-1500 Form and the PSIP Demographic Data Form must be completed for each patient. Photocopied documents/information will be rejected.**

PATIENT INFORMATION: Physicians, or their billing staff 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 (AIA)

EMERGENCY CLAIMS (non-trauma)—SUBMIT CLAIMS TO:

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

E-Mail: AIALAPSIP@MAPINC.COM

AIA Physician Hotline - (800) 303-5242

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.

3. PATIENT'S NAME

   Enter Patient's last name, first name, and middle initial.

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
   Children's 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
   Pomona Valley 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.

COMPLETION OF PSIP DEMOGRAPHIC DATA FORM

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, telephone number and email address of two individuals 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.