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. Patient Name _____
Last First Middle Initial

PHYSICIAN SERVICES

3. PHYSICIAN FUND

☐ (1) Trauma

☐ (2) Emergency Services

Check either box below

4. 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

5. Physician's Name _____ State License # _____

6. Payee Name _____ Payee Tax ID # _____

Payee Address _____

7. Date Billed County (e.g. 01/31/16) ☐☐ ☐☐ ☐☐ Charges $ _____
mm dd yy

FOR QUESTIONS REGARDING THIS CLAIM

8. Contact Person _____ Telephone # _____