COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CHANGE NOTICE FORM

JULY 1, 2025 TO JUNE 30, 2028

GENERAL INFORMATION

Providers must submit a Change Notice Form and supporting documents to American Insurance Administrators (AIA) when any change in the physician information occurs (e.g., office address change, billing company change). Change Notice Forms and supporting documents can be faxed or e-mailed to:

Attention: PSIP Physician Enrollment Dept.
Fax #: (562) 692-8689
E-mail: AIALAPSIP@MAPINC.COM

COMPLETION OF CHANGE NOTICE FORM

A. PROVIDER INFORMATION

ER PHYSICIAN

Check this box if enrolled as Physician and enter name of physician.

ER GROUP

Check this box if enrolled as ER Group and enter name of group.

EFFECTIVE DATE

Check this box and enter the effective date of change.

PAYEE TAX ID

Check this box and enter the nine (9) digit federal tax ID number.

B. CHANGE OF ADDRESS

If provider has changed their payee address (where the Remittance Advice (RA) and check are sent).

W-9 FORM

Check this box and attach a copy of the new W9 Form

PREVIOUS SUBMITTED PROGRAM ENROLLMENT FORM

Check this box and attach a copy of the previously submitted Program Enrollment Form

CONTACT PERSON

Enter contact person's name, telephone #, FAX # and E-mail address.

PREVIOUS ADDRESS

Enter provider's previous address, city, state, and zip code.

NEW ADDRESS

Enter provider's new address, city, state, and zip code.

C. BILLING CHANGE

If provider has changed their biller, or billing company and payee address will not be changing, or provider has gone out of business.

CHANGED BILLER

Check this box if provider changed biller.

CHANGED BILLING COMPANY

Check this box if provider changed billing company.

GONE OUT OF BUSINESS

Check this box if provider has gone out of business.

NAME OF PREVIOUS BILLING COMPANY

Enter previous name of billing company and previous name of billing contact.

PREVIOUS ADDRESS OF BILLING COMPANY

Enter previous address of billing company, city, state, and zip code.

NAME OF NEW BILLING COMPANY

Enter name of new billing company and name of new billing contact (if applicable)

NEW ADDRESS OF BILLING COMPANY

Enter new address of billing company, city, state, and zip code.

TELEPHONE #

Enter telephone #, FAX # and E-mail address of billing contact.

D. CHANGE OF PROVIDER GROUP NAME OR CHANGE OF BILLER AND PAYEE ADDRESS

If provider has changed their group name or changed their biller and payee address (where the Remittance Advice (RA) and check are sent) WILL change, the provider must **re-enroll** in the program.

CHANGE OF PROVIDER GROUP NAME

Check this box If provider group name changed.

CHANGE OF BILLER AND PAYEE ADDRESS

Check this box if provider changed biller and payee address (where the Remittance Advice (RA) and check are sent).

PHYSICIAN'S LICENSURE

Check this box and submit a copy of the physician's current license.

PREVIOUS PROGRAM ENROLLMENT FORM

Check this box and submit a copy of the previously submitted Program Enrollment Provider Form.

W-9 FORM

Check this box and submit a copy of the new W9 Form.

PROGRAM ENROLLMENT PROVIDER FORM

Check this box, complete, and submit a new Program Enrollment Provider Form.

CONDITIONS OF PARTICIPATION AGREEMENT

Check this box, complete, and submit a new Conditions of Participation Form.

E. UPDATED PHYSICIAN LICENSE

Check this box and submit a copy of the new license.

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES
PHYSICIAN SERVICES FOR INDIGENT PROGRAM (PSIP)
CHANGE NOTICE FORM
JULY 1, 2025 TO JUNE 30, 2028

A. PROVIDER INFORMATION: Providers must submit a Change Notice Form and supporting documents to American Insurance Administrators (AIA) when any change in the physician information occurs (e.g., office address change, billing company change).

☐ **ER PHYSICIAN** _____ ☐ **ER GROUP** _____
Physician Name Physician Group Name

☐ EFFECTIVE DATE ____/____/____ ☐ PAYEE TAX ID _____

B. CHANGE OF ADDRESS: If provider has changed their payee address (where the Remittance Advice (RA) and check are sent:

Attach a copy of the: ☐ **W-9 Form** and ☐ **previously submitted Program Enrollment Provider Form**

Contact Person | Telephone # | FAX # | E-mail

Previous Address | City | State | Zip Code

New Address | City | State | Zip Code

C. BILLING CHANGE: If provider has changed their biller, or billing company and payee address will not be changing, or provider has gone out of business:

☐**CHANGED BILLER** ☐**CHANGED BILLING COMPANY** ☐**GONE OUT OF BUSINESS**

Name of previous billing company | Name of previous billing contact

Previous address of billing Company | City | State | Zip Code

Name of new billing company (If applicable) | Name of new billing contact (If applicable)

New address of billing company | City | State | Zip Code

Telephone # | FAX # | E-mail

D. CHANGE OF PROVIDER GROUP NAME OR CHANGE OF BILLER AND PAYEE ADDRESS: If provider has changed their group name or changed their biller and payee address (where the Remittance Advice (RA) and check are sent) WILL change, the provider must re-enroll in the program.

☐ **CHANGE OF PROVIDER GROUP NAME** ☐ **CHANGE OF BILLER AND PAYEE ADDRESS**

Attach a copy of the following:
☐ physician's current license
☐ the previously submitted Program Enrollment Provider Form
☐ the new W9 Form
☐ Complete a new Program Enrollment Provider Form
☐ Complete a new Conditions of Participation Agreement Form

E. UPDATED PHYSICIAN LICENSE: Attach a copy of the ☐ **UPDATED PHYSICIAN LICENSE**

AMERICAN INSURANCE ADMINISTRATORS
PSIP Physician Enrollment Dept
FAX #: (562) 692-8689 **or E-MAIL:** AIALAPSIP@MAPINC.COM
TELEPHONE #: (800) 303-5242