COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

NON-COUNTY PHYSICIANS

INSTRUCTIONS FOR SUBMISSION OF CMS-1500 FORM

JULY 1, 2025 TO JUNE 30, 2028

GENERAL INFORMATION

Physicians must submit an original copy of the **CMS-1500 Form** for each patient's care if they are claiming reimbursement under the County's Physician Services for Indigents Program (PSIP). Information from the CMS-1500 Form is used by the County to comply with state reporting mandates. **Originals of the CMS-1500 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)

TRAUMA CLAIMS - SUBMIT CLAIMS TO:

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

AIA Physician Hotline - (800) 303-5242

COMPLETION OF CMS 1500 FORM

The top section of the CMS-1500 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.

The following CMS-1500 items must be completed

CMS FIELD LOCATION	DESCRIPTION
2	**Patient's Name** Enter Patient's last name, first name, and middle initial.
3	**Patient's Birth date** Enter Patient's Date of Birth and Sex.
5	**Patient's Address** Enter patient's complete address and telephone number.
8	**Reserved for NUCC USE** Enter Patient's TPS # (Trauma patients only). Leave Blank for non-trauma claims.
17	**Name of Referring Provider or Other Source (Physician)** Enter Physician's name.
17a	**State Medical License number** Enter State Medical license number.
18	**Hospitalization Dates Related to Current Services** Enter 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).
21	**Diagnosis or Nature of Illness or Injury** Enter Diagnoses (primary and two others).
24A	**Dates of Service** Enter the date the service was rendered in the "from" and "to" boxes in the MMDDYY format.
24B	**Place of Service** Enter one code indicating where the service was rendered 21-Inpatient Hospital 22-Outpatient Hospital 23-Emergency Room
24D	**Procedures, Services or Supplies** Enter the applicable CPT and/or National codes in this section. **Note:** When completing Section Number 24 (A thru J) all lines are to be utilized before going on to another CMS-1500 form.
25	**Federal Tax ID Number** Enter the Federal Tax ID for the billing provider.
26	**Patient's Account Number** Enter the patient's medical record number of account number in this field.
28	**Total Charge** Enter total for services in dollars and cents.
31	**Signature of Physician or Supplier Including Degrees or Credentials** The claims must be signed and dated by the provider or a representative assigned by the provider in black pen. An original signature is required. Stamps, initials or facsimiles are not acceptable.

COMPLETION OF CMS 1500 FORM

The following CMS-1500 items must be completed

CMS FIELD LOCATION	DESCRIPTION
32	**Service Facility Location Information** Enter the Facility/Hospital Name Enter the Facility/Hospital address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.
32a	**Service Facility Location Information** Enter the NPI of the facility where the services were rendered.
32b	**Service Facility Location Information** Enter the Medi-Cal provider number for an atypical service facility.
33	**Billing Provider Info & Phone Number** Enter the Billing Provider Info & Phone # (Pay-To). Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit zip code, without a hyphen. Enter the telephone number.
33a	**Billing Provider Info & Phone # (Pay-To, NPI)** Enter the billing provider's NPI.
33b	**Billing Provider Info & Phone # (Pay-To) - Used for atypical providers only** Enter the Medi-Cal provider number for the billing provider.