

COUNTY OF VENTURA - HEALTH CARE AGENCY

EMS/CHIP/TSF
PHYSICIAN SERVICES ACKNOWLEDGEMENT FORM

SUBMIT TO: American Insurance Administrators (AIA)
Ventura County EMS/CHIP/TSF Claims
P.O. Box 641635
Los Angeles, CA 90064-1635

The undersigned physician (hereinafter "physician") certifies that claims submitted hereunder are for medically necessary emergency services provided at a hospital and/or medically necessary inpatient or outpatient obstetric, or pediatric services provided to patients who cannot afford to pay, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government. Physician acknowledges receipt of a copy of the "County of Ventura EMS/CHIP/TSF Policies and Procedures" (hereinafter "Procedures"), promulgated by the County of Ventura, Health Care agency, the terms and conditions of which are incorporated herein by reference. Physician hereby agrees to abide by the terms and conditions of the Procedures for all claims submitted under this claiming process.

Physician agrees that all obligations and conditions stated in the Procedures will be observed by him/her, including, but not limited to, the proper refunding of monies to the County of Ventura when patient or third-party payments are made after reimbursement under this claiming process has been received; the cessation of current, and waiver of future, collection efforts upon receipt of payment; and the preparation, maintenance, and retention of service and finance records, including their availability for audit. Physician affirms that for all claims submitted, reasonable efforts to identify third-party payers have been made, no third-party payers have been discovered, and no payment has been received.

Physician expressly acknowledges and accepts that any County liability for claims submitted hereunder is at all times subject to the conditions defined in the Procedures, including, but not limited to, 1) availability of monies in the EMS/CHIP/TSF Uncompensated Care Programs, 2) priority of claim receipt, and 3) audit and adjustments. In accordance with instructions in the Procedures, Physician agrees to submit required documents for claims, and provide other patient data as may be required by the County.

Physician certifies that information on claims submitted by him/her is true, accurate, and complete to the best of his/her knowledge.

TYPE/PRINT NAME OF PHYSICIAN

PRIMARY SPECIALTY OF PHYSICIAN

STATE LICENSE NUMBER

SIGNATURE OF PHYSICIAN

DATE

**one form per batch of claims submitted*