

**Appendix D**

**Emergency Medical Services Appropriation (EMSA)  
Contract Back Program  
MEDICAL SERVICES CLAIM FORM  
FY 200\_\_ - 200\_\_**



**Mail Claims to:**  
California Department of Public Health  
Office of County Health Services  
EMSA Contract Back Program  
**Attn: Marlene Carrillo**  
1616 Capitol Avenue, Suite 74-317  
P.O. Box 997377, MS 5203  
Sacramento, CA 95899-7377

1. Individual / Group **MEDI-CAL** Number  
3 \_ \_ \_ \_ \_ - 0 \_

2. Attending Provider (Last Name, First Name)

3. Solo Physician or Group Name (if applicable)

4. EMSA Provider Enrollment No.

**Patient Information**

5. Patient Last Name

6. Patient First Name

7. Account Number or Last 4 Digits of Social Security Number

8. Patient Date of Birth

9. Gender  
 Male  
 Female

10. State

11. Zip Code

12. Address

13. City

**Facility Information**

14. Name of Facility (Hospital/Clinic/physicians office where medical services were rendered.)

15. Facility Number

16. City

17. Zip Code

18. County Number

19. Facility Setting For Services Rendered  
 1.  Physician's Office      3.  Hospital Emergency Room      5.  Hospital Inpatient Department  
 2.  Free Standing Clinic/Health Center      4.  Hospital Outpatient Department      6.  Other/Unknown

**Date(s) of Service Information**

20. Date of Service

21. Date of Admission (If Applicable)

22. Date of Discharge

**Type of Service and ER Disposition**

23. Type of Service  
 1.  Primary Care      5.  Specialty Care      9.  Home Health Care  
 2.  Laboratory      6.  Optometry      10.  Ambulatory Surgery  
 3.  Medical Supplies      7.  Podiatry      11.  Pharmacy  
 4.  Radiology      8.  Detoxification      12.  Other/Unknown

24. Emergency Room Disposition  
 1.  Released - Non-Emergency  
 2.  Released - Emergency  
 3.  Admitted To Hospital - Non-Emergency  
 4.  Admitted to Hospital - Emergency  
 5.  Deceased

**Treatment Service Information**  
 \*Pursuant to Welfare and Institution Code, Section 16953 "**Emergency**" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which in the absence of immediate medical attention could result in any of the following: placing the patient's health in serious jeopardy; serious impairment to bodily functions; and/or serious dysfunction to any bodily organ or part.

	Procedure Description	Date of Service	*Emergency Service NO or YES	Procedure Code	Quantity	Charges (Round DOWN, NOT UP)
25.		a.	b. <input type="checkbox"/> NO <input type="checkbox"/> YES	c.	d.	e. .00
26.		a.	b. <input type="checkbox"/> NO <input type="checkbox"/> YES	c.	d.	e. .00
27.		a.	b. <input type="checkbox"/> NO <input type="checkbox"/> YES	c.	d.	e. .00
28.		a.	b. <input type="checkbox"/> NO <input type="checkbox"/> YES	c.	d.	e. .00

29. **Total Claim(s) Amount \$ .00**

**\*NOTE: Any additional charges beyond the above 4 entries, MUST BE SUBMITTED ON A SEPARATE CLAIM FORM.**

30. **Affidavit of Physician or Physician's Representative**  
 By submitting and signing this claim form, I, as the attending physician or authorized certified representative, hereby certify that: on the third billing attempt, a copy of the "Notice of Privacy Practices" for the EMSA Contract Back Program (Program) was made available to the patient named on this claim; the information contained on this claim form is true, accurate, and complete; the physician/physician group has read, understands and agrees to be bound by and comply with the policies, conditions and statements contained in the Program's Policies and Procedures Manual, related statutes and regulations and the Program's Annual Enrollment and Certification Form; and I agree to cease all current and future collection efforts when any level of reimbursement of this claim is received from the Program.

Date

Signature of Authorized Representative