

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH  
CHIEF INFORMATION OFFICE BUREAU



**TRADING PARTNER OR AGENT  
DIGITAL CERTIFICATION REQUEST FORM**

THIS FORM IS TO BE COMPLETED BY THE TRADING PARTNER OR THEIR AGENTS ONLY AND  
MUST BE ACCOMPANIED WITH THE CERTIFICATION FROM A THIRD PARTY.

<input type="checkbox"/> New Trading Partner / Agent	<input type="checkbox"/> Existing Trading Partner / Agent
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**Trading Partner Agent Information:**

Name:	
Address:	
City/State /Zip Code:	
Phone Number:	
Fax Number:	
Email Address:	
Signature:	

**Trading Partner Information:**

Legal Entity Name or *FFS Provider Name:	
L. E. or FFS Prov No.	
SSN/Federal Tax ID:	
Address:	
City/State /Zip Code:	
Phone Number:	
Fax Number:	
Email Address:	
Signature:	

**FOR OFFICIAL USE ONLY: To be completed by DMH Chief Information Office Bureau (CIOB).**

User Name:	
Unique Identifier (login name):	
Rendering Provider IS No:	
Approved By:	
Approved Date:	

RETURN THIS FORM TO THE DMH CIOB – EDI CERTIFICATION UNIT