



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.**

New Trading Partner / Agent

Existing Trading Partner / Agent

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 – CERTIFICATION UNIT