



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

Check Submission Form

Submit Forms To:

Department of Health Care Services
Safety Net Financing Division
Targeted Case Management Unit
P.O Box 997436, MS 4603
Sacramento, CA 95899 - 7436
or e-mail at DHCS-TCM@dhcs.ca.gov

This form is to be used by Local Governmental Agencies (LGAs) to refund overpayments made by the Department of Health Care Services (DHCS).

Note: If additional space is needed, use page two to list the Fiscal Year, Invoice Number, and Encounter Number. Please use one form *per* Check Number.
Once the form is complete, sign in **blue** ink, and submit it to the address provided above and enclose check.

LGA:

LGA Coordinator:

Encounter Information:

Fiscal Year:

Invoice Number:

Encounter Number:

Check Information:

Check Number:

Check Amount:

Check Date:

LGA Coordinator (Sign): _____

Phone: _____

LGA Coordinator (Print): _____

Date: _____

Insert Additional Invoices and Encounters here.

Fiscal Year:

Invoice Number:

Encounter Number: