Request for Medi-Cal Expenses Subject to Estate Recovery

Medi-Cal members and their representatives have the right to request a record of Medi-Cal payments made on a Medi-Cal member's behalf that would be subject to an Estate Recovery claim. Please note payment information may change due to adjustment in rates, pending claims from providers, or additional services rendered. The Department of Health Care Services (DHCS) would only have an estate claim for certain services provided on or after a recipient's 55th birthday, unless an individual is/was permanently institutionalized.

The requestor must pay a $5 fee to cover the costs associated with this request. Please make checks payable to the Department of Health Care Services.

To verify your identity, DHCS requires you to send a copy of your photo identification card, such as a California Driver's License or Department of Motor Vehicles Identification Card. To verify an address different than the one indicated on your identification, provide a utility bill or other proof of address. If you do not have access to a California Driver's License, Department of Motor Vehicles Identification Card, or other acceptable document, your signature must be notarized by a licensed notary public. If you are requesting information on behalf of a Medi-Cal member, DHCS requires written proof that you are legally authorized to act on behalf of the Medi-Cal member.

Mail this completed form, check, and supporting documentation to:

Department of Health Care Services
Estate Recovery Section, DHCS 4017
P.O. Box 997425, MS 4720
Sacramento, CA 95899-7425

DO NOT COMPLETE THIS FORM IF:

- You have a personal injury case and Medi-Cal has paid for related services, please call (916) 445-9891
- You are requesting access to records on behalf of a deceased Medi-Cal member, (you may have received an Estate Recovery Questionnaire in the mail), please call (916) 650-0590
- You are involved in a worker's compensation case, in which Medi-Cal has paid for services, please call (916) 445-9891

FORM INSTRUCTIONS:

- Are you requesting your own payment information? If yes, complete Sections 1, 3, and 4, attach proof of your identity and address verification.
- Are you legally authorized to act on behalf of the Medi-Cal member? If yes, complete Sections 1, 2, 3, and 4 and attach proof of your identity and legal authorization.
- If you do not have legal authority to act on behalf of the Medi-Cal member, please have the Medi-Cal member complete Section 1, 3, and 4, attach proof of his or her identity, and direct the payment records be sent to you.

WARNING: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES

SECTION 1: MEDI-CAL MEMBER INFORMATION

(The person who is subject to the records)

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY/STATE	ZIP CODE
MEDI-CAL ID NUMBER	TELEPHONE NUMBER	DATE OF BIRTH

SECTION 2: LEGALLY AUTHORIZED INDIVIDUAL INFORMATION

You must attach written documentation to verify your legal authority to act on behalf of the Medi-Cal member. Examples of documents that prove authorization to request payment records include: legal documents appointing you as guardian or conservator of the individual whose records you seek; financial, medical, or durable power of attorney signed by the individual whose records you seek. If you do not have written documentation of your legal authority, please have the Medi-Cal member complete the form and request the records be sent to you in Section 4.

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS	CITY/STATE	ZIP CODE
TELEPHONE NUMBER		

INDICATE YOUR LEGAL AUTHORITY TO REQUEST RECORDS OF THE MEDI-CAL MEMBER:

☐ Guardian	☐ Conservator
☐ Financial Power of Attorney	☐ Medical Power of Attorney
☐ Durable Power of Attorney	☐ Other, please describe

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SECTION 3: IDENTIFYING INFORMATION

If you are the Medi-Cal member, please provide a copy of your identification and address verification, and sign the certification. If you are the legally authorized representative, please provide your identification and address verification, and sign the certification.

Please attach a copy of one of the following documents:

☐ California Driver's License, Number

☐ California DMV Identification Card, Number

☐ Birth Certificate, State

☐ Other Identification Document (e.g. passport, school ID, etc.)

Please attach a document that verifies your address. **If the address on your Driver's License, DMV ID card, or other document matches the address in Section 4, this is not required.**

☐ TYPE: (For example, a utility bill or phone bill)

CERTIFICATION:

I declare under penalty of perjury that the information on this form is true and correct.

MEDI-CAL MEMBER/REPRESENTATIVE SIGNATURE

DATE

NOTE: If you do not attach a copy of your identification, your signature must be notarized.

NOTARIZED BY ON (DATE)

NOTARY PUBLIC NUMBER

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

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SECTION 4: WHERE OR HOW WOULD YOU LIKE TO OBTAIN YOUR PAYMENT RECORDS?

☐ Please mail me a copy of the requested records at the address in Section 1 (Medi-Cal member address).

☐ Please mail a copy of the requested records to the address in Section 2 (legally authorized representative address).

☐ Please mail a copy of the requested records to the person of my choosing indicated below.*

***NOTE: Any person may be named below. The Department will not send records to photocopy services.**

NAME

FIRM

ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE NUMBER

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