Request for Medi-Cal Expenses Subject to Estate Recovery

Beneficiaries and their representatives have the right to request a record of Medi-Cal payments made on a beneficiary's behalf. 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 services received on or after a recipient's 55th birthday, unless an individual is/was permanently institutionalized.

The requestor must pay a $25 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 beneficiary, DHCS requires written proof that you are legally authorized to act on behalf of the beneficiary.

Mail this completed form, check and supporting documentation to:

Department of Health Care Services
Estate Recovery Section
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 beneficiary, (you may have received an Estate Recovery Questionnaire in the mail), please call 916-650-0490
- You are involved in a worker's compensation case, in which Medi-Cal has paid for services, please call Health Management Systems, Inc. at 916-760-5100

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 someone else? 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, please have the beneficiary 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: BENEFICIARY 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

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

INDICATE YOUR LEGAL AUTHORITY TO REQUEST RECORDS OF THE BENEFICIARY:

☐ Parent of Minor Child ☐ Personal Representative

☐ Guardian ☐ Conservator

☐ Executor of Will ☐ Power of Attorney

☐ Other, Please Describe:

Note: You must attach written documentation to verify that you are the parent, personal representative, conservator, guardian, executor of a decedent's will, or have medical decision-making authority for the individual. Examples of documents which prove authorization to request payment records include: a birth certificate for your minor child; legal documents appointing you as guardian, conservator, or executor for the individual whose records you seek; or a medical power of attorney signed by the individuals whose records you seek.

If you do not have written documentation of your legal authority, please have the beneficiary complete, sign and request the records be sent to you in Section 4.

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SECTION 3: IDENTIFYING INFORMATION

If you are the beneficiary, please provide a copy of your identification, address verification and sign the certification. If you are the legally authorized representative, please provide your identification, 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 Sections 1 or 2, this is not required.**

☐ TYPE: (For example, a Utility Bill or Phone Bill)

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

CERTIFICATION:

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

BENEFICIARY/REPRESENTATIVE SIGNATURE

DATE

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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 (beneficiary's address).

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

☐ I request that a person of my choosing be allowed to inspect my records.

NOTE: Any person or law firm 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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