

## COMMITMENT TO PAY REIMBURSABLE MEDI-CAL LIEN AMOUNT

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Beneficiary Name:  
DHCS Account Number:

Instructions: This form is to be used by the Beneficiary's attorney when the Department of Health Care Services (Department) is one of the parties named on a negotiable instrument/check, and the beneficiary's attorney is requesting that the Department endorse it.

Complete this form, sign, date, and mail along with the negotiable instrument/check to:

Department of Health Care Services  
Casualty Insurance Section  
MS 4720, P.O. Box 997421  
Sacramento, CA 95899-7421

Contact the Department's Casualty Insurance Section at (916) 445-9891 with any questions.

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"I, \_\_\_\_\_, request that the Department of Health Care Services

(Attorney's full name)

endorse the enclosed negotiable instrument/check and return it to me. I represent the above-named Beneficiary and am managing the negotiable instrument/check and the funds received from cashing it on behalf of the Beneficiary.

By my signature below, I am committing to deposit this negotiable instrument/check, acquire the funds, and to remit to the Department the reimbursable Medi-Cal lien amount owed by the Beneficiary to the Department.

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Attorney's Signature

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Date