Instructions for Submitting a Medi-Cal Claim Form for Beneficiary Reimbursement (Medical or Dental Payment Refund)

Who May File a Claim?

Anyone who has paid for medical or dental services that they think are normally covered by Medi-Cal may file a claim for a refund. Anyone filing on behalf of the beneficiary must include their relationship to the beneficiary when signing the form or any related documents. To get a refund, you must have received and paid for the service:

A. During the retroactive eligibility period of up to three months prior to the date of your filed application that must have already been granted by your county and documented on your file; or

B. While you waited for your Medi-Cal application to be decided. If you received services on or after February 2, 2006, to get a refund for payments, you must have paid a provider who accepts Medi-Cal; or

C. After you received your Medi-Cal card. To get a refund for payments made after you received your Medi-Cal card, you must have paid a provider who accepts Medi-Cal.

How Do I File a Claim?

To file a claim, you must submit a Medi-Cal Claim Form for Beneficiary Reimbursement.

- The claim form must be filled out in blue or black ink;
- The claim form must have an original signature (no copies will be accepted);

The Claim Form must include:

- A photo copy of your Medi-Cal Beneficiary Identification Card (BIC).
- Proof of payment. Examples include a copy of a cancelled check(s) from the bank (front & back), receipt(s) from the provider you paid, evidence of electronic payment, or a copy of a money order. A declaration may be used in some situations to explain, supplement or support the documents above.
- A completed PAYEE DATA RECORD Form.
- For those services that would have required Medi-Cal authorization, documentation from the medical or dental provider that shows medical necessity for the service.
- An itemized billing statement indicating the date(s) of service; and the service(s) and/or service code(s) for which you paid out-of-pocket to the provider(s).

Note: Please complete an individual Provider Information page for each of the providers and be sure to list the amount (you wish to be reimbursed) that you paid to each of the providers.

What is Timely Filing?

1. Claims for services provided on June 27, 1997 through November 16, 2006: For services provided between June 27, 1997 and November 16, 2006, your claim must be received by November 16, 2007 or within 90 days of receipt of your Medi-Cal card, whichever is later.
2. Claims for service(s) provided on or after November 16, 2006: For service(s) provided on or after November 16, 2007, your claim must be received within one year of the date that you received the service(s) or within 90 days of receipt of your Medi-Cal card, whichever is later.

Where Do I Send Claims?

1. Claims for refunds for payments made for Medical, Mental Health, Alcohol and Drug Program treatments, and In Home Supportive Services Should be mailed to:
   Beneficiary Service Center, P.O. Box 138008, Sacramento, CA 95813-8008
2. Claims for refunds for payments made for dental services should be mailed to:
   Beneficiary Service Center, P.O. Box 526026, Sacramento, CA 95852-6026

Medi-Cal Claim Form For Beneficiary Reimbursement (Medical or Dental Payment Refund)

If you have any questions please refer to the enclosed instructions or call the Beneficiary Service Center (BSC) at (916) 403-2007. For TDD service call (916) 635-6491.

Beneficiary (Patient) Information: Please fill in all the information requested below in blue or black ink.

Last Name:	First Name:	Middle Initial:

Home Address (Number & Street):	Apartment Number:	Home Phone:

City:	State:	Zip:	County:	Work Phone:

Mailing Address (if different from above or P.O. Box):	Message Phone:

City:	State:	Zip:

Social Security Number:	Date of Birth (MM/DD/YYYY):	Medi-Cal ID Number (BIC):

Include a completed Payee Data Record and a copy of your Medi-Cal card.

I. List each of the medical or dental provider(s) to whom you have made payment(s) and wish to seek a refund of the payment(s):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

II. Please complete separate pages 3 and 4 of this form for each provider listed above. Individual copies of pages 3 and 4 must be completed for each one of the providers listed above. Only pages 3 and 4 may be photocopied. Or to request copies of pages 3 and 4 call the BSC at (916) 403-2007, or (916) 635-6491 for TDD.

III. Sign and date the bottom of this page and sign and date each copy of page 3 you are including with this claim. Be sure to print your name and relationship.

Beneficiary Agreement: (May include legal representative or authorized representative along with a copy of the legal documents authorizing you to represent the Beneficiary/Patient)

I declare under penalty of perjury under the laws of the State of California that all of the information on this claim form is true and accurate to the best of my knowledge and belief. I authorize any provider of care or other entity who provides health care services to the beneficiary listed above to release to the Companies and/or their parent, affiliates or designees any information or medical records relating to these services. I also authorize Medi-Cal to receive and release such information in connection with processing claims, medical management programs or carrying out any other lawful purpose relating to participation in the health benefits plan. I understand that Medi-Cal will treat all personal health information and that of all covered family members, as confidential and will not disclose it for any other purpose.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

(Beneficiary/Patient, Legal Representative or Authorized Representative)

Provider Information
(Individual Providing Medical or Dental Services)

I have made the listed payment to the following provider for the described medical or dental services and request reimbursement for Medi-Cal covered services.

Name of Provider:	Medi-Cal Provider Number: (if known)

Contact Name:	Contact Phone Number:

Physical Address: (number and street)	Phone Number:

City:	State:	Zip:

Date(s) Service(s) Provided:	Total Amount Paid to this Provider:

Description of Service(s) If you need more room to describe the service(s), use the next page:

✓ Please include photocopies of:

- Proof of all payments
- Documentation of medical necessity if required
- Any documents or paperwork that supports your claim
- An itemized billing statement indicating the date(s) of service, and the service(s) and/or service codes for which you paid out-of-pocket to the provider(s)

Beneficiary Agreement: (May include legal representative or authorized representative along with a copy of the legal documents authorizing you to represent the Beneficiary/Patient)

I declare under penalty of perjury under the laws of the State of California that all of the information on this claim form is true and accurate to the best of my knowledge and belief. I authorize any provider of care or other entity who provides health care services to the beneficiary listed above to release to the Companies and/or their parent, affiliates or designees any information or medical records relating to these services. I also authorize Medi-Cal to receive and release such information in connection with processing claims, medical management programs or carrying out any other lawful purpose relating to participation in the health benefits plan. I understand that Medi-Cal will treat all personal health information and that of all covered family members, as confidential and will not disclose it for any other purpose.

Print Name: _____ Relationship: _____

Signature: _____ Date: _____
(Beneficiary/Patient, Legal Representative or Authorized Representative)

Official Use Only	☐ ADP	☐ Medical	☐ MMCD
☐ Retro	☐ Dental	Other: _____	
☐ Evaluation	☐ DMH	County of Service: _____	
☐ Post	☐ IHSS	Case Number:	

Description of Service(s) (continued):