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

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

April 11, 2003

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS

LETTER NO: 03-17

SUBJECT: MEDI-CAL CONTACT INFORMATION RELEASE FORM (MC 354)
(Ref.: All County Welfare Directors Letter (ACWDL) No. 01-36 and 01-39)

Welfare and Institutions Code section 14005.36(c), which is part of Senate Bill (SB) 87, Chapter 1088, Statutes of 2000, mandates the counties to incorporate, in a timely manner, updated beneficiary contact information received from a managed care health plan into the beneficiary's Medi-Cal case file. Contact information is defined as the beneficiary name, address and telephone number. SB 87 instructs the Department of Health Services (DHS) to create a beneficiary consent form permitting counties to update Medi-Cal case files with updated contact information received from a managed care health plan.

The MC 354 form was developed in collaboration with counties and consumer advocates. The DHS' Medi-Cal Managed Care Division (MMCD) released MMCD All-Plan Letter No. 03002 dated January 31, 2003, with the MC 354 form and instructions to managed care health plans. The managed care health plans may develop their own form using the elements contained in the MC 354 form but are encouraged to adopt the MC 354 form to maintain consistency within and across counties. The managed care health plan is responsible for forwarding the form to the county. County staff are required to review any MC 354 received at the county office from a managed care plan and update the beneficiary's Medi-Cal case file if necessary. Section 14005.36(c) permits counties to attempt to verify the accuracy of the information before incorporating it in the file. The completed and signed MC 354 must be maintained in the beneficiary's current Medi-Cal case file.

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The MC 354 is not an eligibility requirement of the Medi-Cal program. Refusal to sign or complete this form will not affect the beneficiary's Medi-Cal eligibility. A copy of MMCD All-Plan Letter No. 03002 is enclosed with this ACWDL for your reference.

If you have questions regarding the MC 354 or its use, please contact Ms. Alice Mak of my staff by phone at (916) 654-0573 or via e-mail at amak@dhs.ca.gov.

Original signed by

Beth Fife, Chief
Medi-Cal Eligibility Branch

Enclosure

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January 31, 2003

MMCD All-Plan Letter No. 03002

TO: County Organized Health System Plan (COHS)
Geographic Managed Care (GMC) Plans
Prepaid Health Plans (PHP)
Primary Care Case Management (PCCM) Plans
Two-Plan Model Plans

FROM: Luis R. Rico, Acting Chief
Medi-Cal Managed Care Division

SUBJECT: Senate Bill 87: Medi-Cal Contact Information Release Form

BACKGROUND:

Senate Bill (SB) 87 requires counties to update the Medi-Cal case files of beneficiaries when certain contact information is received from a managed care health plan. This requirement applies only if the beneficiary provides consent. The Department of Health Services (DHS) has developed a form entitled, Medi-Cal Contact Information Request Form, MC 354, (enclosed). This form is intended for use by managed care health plans to record contact information changes and beneficiary consent. The updated contact information recorded in a beneficiary's Medi-Cal case file by counties will also result in updating DHS' managed care enrollment systems and all member data transmitted to the health plans. Contact information is limited to a beneficiary's telephone number, change of address, and change of name.

Senate Bill (SB) 87 also addresses the Medi-Cal redetermination process. Please see the enclosed All County Welfare Directors Letter (ACWDL) #'s, 01-17, 01-36, and 01-39 for more information.

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PURPOSE:

The MC 354 form was developed as a method to transmit a beneficiary's permission to the local County Social Service Department to update their Medi-Cal beneficiary case file with contact information received from a managed care health plan.

MEDI-CAL CONTACT INFORMATION RELEASE FORM (MC 354)

Contact information is limited to the individual's (and his/her family's) name, address and telephone number. The form is designed to capture both the signed consent authorizing the county to make changes and the actual contact information changes.

The managed care health plan should send MC 354 forms to members who have notified them of a change of name, address, or telephone number. The managed care health plan may also distribute the MC 354 to their contracted providers to facilitate ease of access to the forms which should then be returned to the health plan upon completion and signature.

Managed care health plans are encouraged to ask their providers to make Medi-Cal beneficiaries aware of the MC 354 form and recommend that the beneficiary complete and sign this form when there is a change in their name, address or telephone number.

It is recommended that the provider review the MC 354 to ensure that the form has been filled out completely and accurately. The form should then be sent to the beneficiary's managed care health plan. The managed care health plan is responsible for forwarding the form to the County Social Services Department. Counties will then incorporate the required changes to the beneficiary's Medi-Cal case file, and the Medi-Cal Eligibility Data System (MEDS).

Although the MC 354 form was developed in collaboration with counties and consumer advocates, managed care health plans may develop their own form using the elements contained in the MC 354 form. Managed care health plans are, however, encouraged to adopt the MC 354 to maintain consistency within and across counties.

The intent of SB 87 is to improve the maintenance of current and accurate beneficiary information that will increase efficiency and improve communication with the Medi-Cal population. It is recommended that managed care health plans coordinate with their respective County Department of Social Services to ensure successful implementation of this new process.

The MC 354 form is not a requirement of the Medi-Cal program. Refusal to sign or complete this form will not affect the beneficiary's Medi-Cal eligibility.

If there are questions concerning these instructions, please contact Mr. Marcine Crane, Chief, Two-Plan Model Section, at (916) 657-0215.

Enclosures

MEDI-CAL CONTACT UPDATE FORM

PLEASE FILL IN NUMBERS 1. THROUGH 4., AND SIGN NUMBER 5. BELOW:

1. New Contact Information	2. Old Contact Information
Name (print)	Name (print)
Address (number, street, apt.)	Address (number, street, apt.)
City (print) State Zip Code	City (print) State Zip Code
Mailing Address (if different from above)	Mailing Address (if different from above)
City (print) State Zip Code	City (print) State Zip Code
Telephone Number ( )	Telephone Number ( )

3. Your Health Plan Information	4. Personal Information
Health Plan Name (print)	Your Date of Birth
Your Health Plan Number	Your Beneficiary Identification Card (BIC) Number

PLEASE READ THE FOLLOWING BEFORE SIGNING BELOW:

You can help us keep your Medi-Cal contact information current by completing, signing, and turning in this form. It allows your managed care plan to share with your county Medi-Cal office any **name, address,** and/or **telephone number** changes you make. This form will help in making sure that you receive the most current information about your Medi-Cal benefits.

The county Medi-Cal office may not be able to update your Medi-Cal case file with your **name, address,** and **telephone number** change if this form is not completed and signed by you. **Don't forget** that Medi-Cal rules require you to report a change of address to the county Medi-Cal office within ten days.

5. PLEASE PRINT YOUR NAME, SIGN, AND DATE IN THE AUTHORIZATION BOX BELOW:

I, (print name)_____, give permission for the county Medi-Cal office to update my Medi-Cal case file, and those of my family members with any changes in information regarding my **name, address,** and/or **telephone number** that I report to my managed care plan. I understand that I will need to complete a new form every time I have a change to my **name, address**, and/or **telephone number**.

_____ _____
Signature Date

COUNTY INFORMATION (TO BE FILLED IN BY COUNTY STAFF)

Case number	Worker name	Worker number	Worker telephone number ( )