CHANGE OF STATUS–LIENS

Name of Beneficiary	Medi-Cal Identification Number	Social Security Number
	__ __ – __ __ – __ __ __ __ __ __ __ – __ – __ __	

❒ Discharged from long-term care and returned home on ______________________

❒ Requested a county level review on ______________________

❒ Requested a state hearing/rehearing on ______________________

❒ County level review decision issued on ______________________

❒ State hearing/rehearing decision issued on ______________________

Lien may be recorded ❒ Yes ❒ No

Beneficiary's Address (number, street)	City	State	ZIP Code

❒ Other information/changes:

____

____

Eligibility Worker signature	Eligibility Worker number	Telephone number	Date
		( )	

Mail to: Department of Health Care Services
Third Party Liability and Recovery Division
Estate Recovery Section
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425
Telephone number: (916) 650-0490

State of California—Health and Human Services Agency

Department of Health Care Services

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DHCS 7013 (06/07)

INSTRUCTIONS FOR DHCS 7013
CHANGE OF STATUS–LIENS

The form is completed in duplicate; the original sent to DHCS Recovery, the copy retained in the case record.

1. Enter beneficiary's full name, Medi-Cal ID number, and Social Security number.
2. Check box and enter requested information.
3. Eligibility Worker signs and dates form.

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

INSTRUCTIONS FOR DHCS 7013
CHANGE OF STATUS–LIENS

The form is completed in duplicate; the original sent to DHCS Recovery, the copy retained in the case record.

1. Enter beneficiary's full name, Medi-Cal ID number, and Social Security number.
2. Check box and enter requested information.
3. Eligibility Worker signs and dates form.

DHCS 7013 (06/07)