MEDI-CAL CONTACT UPDATE

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 State ZIP code	City State ZIP code
Mailing address (if different from above)	Mailing address (if different from above)
City State ZIP code	City 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 ( )