MICHELLE BAASS
DIRECTOR

State of California—Health and Human Services Agency

Department of Health Care Services

GAVIN NEWSOM
GOVERNOR

Check Submission Form

Submit Forms To:

Department of Health Care Services
Local Governmental Financing Division
Targeted Case Management Unit
P.O Box 997436, MS 4603
Sacramento, CA 95899 - 7436
or e-mail at DHCS-TCM@dhcs.ca.gov

This form is to be used by Local Governmental Agencies (LGAs) to refund overpayments made by the Department of Health Care Services (DHCS).

Note: If additional space is needed, use page two to list the Fiscal Year, Invoice Number, and Encounter Number. Please use one form *per* Check Number.
Once the form is complete, sign in blue ink, and submit it to the address provided above and enclose check.

LGA: ____________ **LGA Coordinator:** ____________

Encounter Information:

Fiscal Year: ____________ Invoice Number: ____________ Encounter Number: ____________

Check Information:

Check Number: ____________ Check Amount: ____________ Check Date: ____________

LGA Coordinator (Sign):____________ Phone: ____________

LGA Coordinator (Print):____________ Date: ____________

Insert Additional Invoices and Encounters here.

Fiscal Year:	Invoice Number:	Encounter Number: