State of California
Health and Human Services Agency

Department of Health Care Services

# COMMITMENT TO PAY REIMBURSABLE MEDI-CAL LIEN AMOUNT

Medi-Cal Member Name:

DHCS Account Number:

Instructions: This form is to be used by the attorney representing the Medi-Cal Member (Member) when the Department of Health Care Services (Department) is one of the parties named on a negotiable instrument/check, and the Member's attorney is requesting that the Department endorse and return it to the specified address.

Do not endorse the negotiable instrument/check prior to receiving the Department's endorsement.

Complete this form, sign, date, and mail along with the negotiable instrument/check to:

Department of Health Care Services
Third Party Liability and Recovery Division
P.O. Box 997421, MS 4720
Sacramento, CA 95899-7421

Contact the Department's Phone Support Unit at (916) 445-9891 with any questions.

"I, , an attorney licensed in the State of California, request that the Department of Health Care Services endorse the enclosed negotiable instrument/check and return it to me. I represent the above-named Member and am managing the negotiable instrument/check and the funds received from cashing it on behalf of the Member.

By signing below, I commit to remitting to the Department the reimbursable lien amount owed by the Member within 20 calendar days. If the Department's reimbursable lien amount has not yet been determined, I agree to hold in trust no less than one half of the net settlement and reimburse the Department within 20 calendar days of receiving the Department's lien.

Attorney's Signature

Date