



CalOptima NOTIFICATION OF CHANGE OF "PAY TO" ADDRESS FORM

I hereby request that the pay-to address of _____
(LTC Facility Name)

(LTC Facility Medi-Cal Number) (Effective Date of Change MM/DD/YY)

Is this a new billing company? Yes No If yes is checked please provide billing company name in new address.
Old Address:

New Address/Billing Company Name: _____

I hereby unconditionally release and forever discharge CalOptima and each and all of its agents, officers, and employees from any and all claims, damages, costs, expenses, and rights to compensation whatsoever, which I now have or which may hereafter accrue on account of, or in any way as a result of this notice of change of address.

I (WE), THE UNDERSIGNED, HAVE READ THIS RELEASE AND FULLY UNDERSTAND IT.

Dated this _____ day of _____, 20 _____,

Federal Tax ID#: _____

Authorized Signature

Title and Phone Number

Corporation Name

State of California
County of _____ } ss.

On _____, before me, _____, personally
Date

appeared _____,

personally know to me proved to me on the basis of satisfactory evidence

to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person or the entity upon behalf of which the person acted, executed the instrument.

Signature of Notary Public

This form must be signed, notarized and returned to

CalOptima Provider Enrollment
P.O. Box 11033
Orange, CA 92856
Ph: 714-246-8468 Fax: 714-246-8448

Note: Any change of "Service" address for Long Term Care or Inpatient/Outpatient providers must be processed by the local Licensing and Certification Division of the Department of Health Services. If you cannot contact the local branch, call Licensing and Certification headquarters in Sacramento at (916) 445-2070 for more information.



CalOptima NOTIFICATION OF CHANGE OF FEDERAL TAX I.D. FORM

I hereby request that the Federal Tax I.D. number of _____
(LTC Facility Name)

(LTC Facility Medi-Cal Number and Reason for change)

Be changed from Old Federal Tax I.D. #: _____ Effective Date _____
To New Federal Tax I.D. #: _____ Effective Date _____

(New W-9 must be submitted with this form)

I hereby unconditionally release and forever discharge CalOptima and each and all of its agents, officers, and employees from any and all claims, damages, costs, expenses, and rights to compensation whatsoever, which I now have or which may hereafter accrue on account of, or in any way as a result of this notice of change of Federal Tax I.D. number.

I (WE), THE UNDERSIGNED, HAVE READ THIS RELEASE AND FULLY UNDERSTAND IT.

Dated this _____ day of _____, 20 _____,

Pay To Address: _____
_____ Authorized Signature
_____ Title and Phone Number
_____ Corporation Name

State of California }
County of _____ } ss.

On _____, before me, _____, personally
Date

appeared _____,

personally know to me proved to me on the basis of satisfactory evidence

to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person or the entity upon behalf of which the person acted, executed the instrument.

Signature of Notary Public

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Note: Any change of Federal Tax I.D. Number for Long Term Care or Inpatient/Outpatient providers must be processed by the local Licensing and Certification Division of the Department of Health Services. If you cannot contact the local branch, call Licensing and Certification headquarters in Sacramento at (916) 445-2070 for more information.