Notification of Change of Federal Tax I.D. Form

I/We, _____,
(Provider Name)

_____, hereby request that my/our Federal Tax I.D. number be changed
(Medi-Cal Number)

From Old Federal Tax I.D. #: _____

To New Federal Tax I.D. #: _____ Effective Date: _____
(MM/DD/YY)

(NEW W-9 MUST BE SUBMITTED WITH THIS FORM)

Reason for Change: ☐ Ownership Change ☐ Other (specify):_____

I/We 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/we 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

_____
Corporation Name

State of California
County of _____ } ss.

On _____, before me, _____, personally
Date

appeared_____,

☐ personally known 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 Data Management Department
505 City Parkway West
Orange, CA 92868
Email: provideronline@caloptima.org
Ph: 714-246-8468 Fax: 714-954-2330

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.