CalOptima NOTIFICATION OF CHANGE OF "PAY TO" ADDRESS FORM

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

_____ _____
(Provider 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

_____
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
(714) 246-8468

Note: Any change of "Service" address for providers must be submitted and 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.

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