CMSP Member Change Request

County Medical Services Program

Fax to 858-578-2135

TYPE OF CHANGE (Please check only one) **Add** ☐
CARRIER HQ : CMSP1/CMSP2

Requester:		Phone No.: - -	Fax No.: - -
Email:		Title:	Date: / /

MEMBER INFORMATION

Effective Date: / /

Street:	County Name:
Address Con't:	*County Code:
City: State: ZIP:	*Aid Code:

Relation /Person code	*Last Name	*First Name	*Gender= M/F	*DOB	*Member CIN#
Ins/01				/ /	

*** Does this member have an SOC requirement?** ☐ **Yes** ☐ **No**

Comments:

*** - MANDATORY fields.** All other fields need to be filled out as necessary according to Plan needs.

Solano and Sonoma Counties Only: To expedite processing, do not wait for the CIN# to be issued before submitting this member add form to MedImpact. Please fax immediately and no greater than 1 hour from granting of eligibility to MedImpact.

Acceptance Agreement: County Medical Services Program is solely responsible for ensuring the accuracy of eligibility information provided to MedImpact and shall be obligated to pay MedImpact for claims accepted by MedImpact that are submitted by or on behalf of persons included on any eligible information provided to MedImpact. My signature below affirms that the information on this form is complete and accurate to the best of my knowledge.

X ____________________________________ Date: / /

Signature of Authorized Plan Representative Required