COUNTY REQUEST FOR COUNTY MEDICAL SERVICES PROGRAM (CMSP) CLAIMS DETAIL

Instructions: The County must provide the following information in order to determine the amount of CMSP benefits provided during the period a potential overpayment occurred. Complete ***one*** form for ***each person*** in ***each incident*** and forward to:

County Medical Services Program
Governing Board
Attention: Data Section
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Failure to fully complete this form will result in a delay in the processing of this request. ***The county should not forward any other forms, materials, or data with this form.*** Upon receipt, the CMSP Governing Board Data Section will log this request and, in six months from the date the potential overpayment period ended, order the claims detail. This delay is necessary to capture the claims associated with the request. The county should expect the ***claims data to be returned seven months from the end of the overpayment period.***

1. County name	
2. Recipient first name	
3. Recipient last name	
4. MEDS ID number (14-digit)	
5. Recipient social security number	
6. BDOF—Beginning Date of Potential Overpayment/Fraud Activity	
7. EDOF—Ending Date of Potential Overpayment/Fraud Activity	

County mailing address: _____

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Signature of person completing form ➢	Date
Title	Phone number ( )