State of California
Health and Human Services Agency

Department of Health Care Services

Medi-Cal Rx Replacement Check Form

Pharmacy Name: _____

Pharmacy Pay-To Address: _____

_____

National Provider Identifier (NPI) & Owner Number: _____

Check Number (if known): _____

Check Date (if known): _____

Check Amount (if known): _____

Add any additional information related to your request: _____

_____

_____

_____

☐ Reissue the check and send it to the pay-to address listed above. Note that if the address listed above does not match the pay-to address on file, the Medi-Cal Rx Finance Department will contact you, which will delay the reissuance of the check.

☐ The pay-to address has changed and has been updated via the PAVE Portal at https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx. Reissue the check.

Mail this form to:

Medi-Cal Rx Customer Service Center
ATTN: Finance Department
P.O. Box 610
Rancho Cordova, CA 95741-0610

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by DHCS for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in the Provider's request being delayed or not being processed.

Signature of Authorized Provider Representative: _____

Print Name: _____ Date: _____