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| **REQUESTER:** * **Use Form A to request CHANGES/CORRECTIONS to the Core Client Information (CCI), DEMOGRAPHIC FORM, and/or CLIENTS 3RD PARTY COVERAGES only.**
* **Only TYPED Forms will be accepted effective 05/15/2019.**
* **Complete fields in each column as instructed.**
* **Fax this form along with any supporting documents e.g. ID, Medi-Cal card, Immigration, Adoption.**

 **\*Medical Policy & Effective date can be found in *Clinicians Homepage “Insurance Coverag*e” Tab** |
| **Section #1 - REQUESTER INFORMATION** |
| **Date of Request** |    /    /      | **Form completed by:** |       |
| **Program Name** |       | **Your Phone #** | **(**     **)**     **-**      | Ext #      |
| **Unit/SubUnit #** |      /      | **Your Fax #** | **(**     **)**     **-**      |

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| **Section #2 - CLIENT INFORMATION** |
| **CCI Data Fields- To find CCI - Right click on patient name, select “Show Core Client Information”** | **Client Record** **As Data CURRENTLY Appears in the Core Client Information (CCI) window** **Leave field blank if data not available** | **Change Client Record TO:** **Complete ONLY fields that need to be changed****(Exactly as it should be entered in CCI)** |
| **Case Number** |       |  |
| **Sort Name** |       |       |
| **Client Name** |       |       |
| **Date of Birth****(mm/dd/yyyy)** |    /    /      |    /    /      |
| **Sex/Gender** | **[ ] Female [ ] Male [ ] Other [ ] Unknown** | **[ ]  Female [ ] Male** |
| **Social Security #** |     -   -      |      -   -      |
| **\*Medi-Cal Policy #/eff date (mm/dd/yyyy)** |        |    /    /      |       |    /    /      |
| **Remarks /****Additional Information** |       |
| **STOP – DO NOT ENTER INFORMATION BELOW THIS LINE. HIMS USE ONLY.** |
| **[ ]  NOTICE TO REQUESTER:** **Unable to confirm change should be made** | **Reason:**       |
| **CLIENT INFORMATION TO BE KEPT IN CCBH** |
| **Case Number** |       | **Date of Birth****(mm/dd/yyyy)** |    /    /      |
| **CCBH Sort Name** |       | **Social Security #** |     -    -      |
| **Client Name** |       | **Medi-Cal Policy # /eff date** |       |   /    /     |

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| **Date completed by HIMS** |    /    /      | **HIMS Staff CCBH ID # and Name** |       |

**[ ]  Sent to MHBU [ ] Core Client Information (CCI) Updated [ ]  N/A [ ] Demographic Form Updated**