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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**