MEDI-CAL ELIGIBLITY DATA SYSTEM (MEDS) ACCOUNT REQUEST

Submit Form: Fax: (916) 440-5346 or
Scan and email: cmshelp@dhcs.ca.gov

Questions? Contact the CMS Net Help Desk
(866) 685-8449 or cmshelp@dhcs.ca.gov

This form is to request MEDS access activation or deletion for State, county and local program staff supported by the CMS Branch. When the "Add" option is selected the user will be assigned a new User ID and temporary password. The form is also to be used to request deactivation of a user's MEDS ID. Please type or print legibly and allow one week for processing new requests.

County/Local Program: _____

Select One	Name (Last, First)	Email Address	Phone (999)999-9999	Last 4 digits of SSN
☐ Add ☐ Delete				
☐ Add ☐ Delete				
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☐ Add ☐ Delete				
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Address: _____

Representative's Name (Print): _____ Phone: _____

Representative's Name (Signature): _____ Date: _____

DEPARTMENT OF HEALTH CARE SERVICES COMPUTER FILES

RELEASE/ACCESS OF THE MEDI-CAL PROGRAM CONFIDENTIALITY OATH

As a condition of obtaining access to information concerning procedure or other data and records utilized/maintained by the California Department of Health Care Services, I agree not to divulge any information obtained in the course of my assigned duties to unauthorized persons, and I agree not to publish or otherwise make public any information regarding persons(s) receiving Medi-Cal services such that the persons who received such services are identifiable.

Access to such data shall be limited to state and federal personnel who require the information in the performance of their duties and to such others as may be authorized by the California Department of Health Care Services.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code, Section 14100.2.

County/Local Program: _____

Printed Name of Staff	Staff Signature	Date

INSTRUCTIONS

County/Local Program:	The name of the county or local program submitting request.
Select One:	
Add:	Select check box if this request is for account activation.
Delete:	Select check box if this request is for account deactivation.
Name (Last, First):	Type user's last name, then user's first name.
Email Address:	Type user's email address.
Phone:	Type user's phone number, including area code (and extension if applicable) in format (999)999-9999.
Last 4 Digits of SSN:	Type the last four digits of the user's Social Security Number (SSN).
Address:	Type the work address of the users listed above. Include number, street, suite number, city or town, state, and ZIP code. If more than one location, list the primary work address of the office or use a different form for each address.
Representative's Name (Print):	Type the name of the person submitting request. Representative must be a State CMS Branch manager, California Children's Services (CCS)/CMS Administrator, Child Health and Disability Program (CHDP) Director, CHDP Deputy Director.
Phone:	Type the representative's phone number, including area code (and extension if applicable) in format (999)999-9999.
Representative's Name (Signature):	Signature of representative.
Date:	Date account request was signed by the representative.
County/Local Program:	The name of the county or local program submitting request.
Printed Name of Staff:	Name of user with the "Add" option selected. Each user with the "Add" option selected must be listed and sign the confidentiality oath.
Staff Signature:	Signature of user with the "Add" option selected. Each user with the "Add" option selected must be listed and sign the confidentiality oath.
Date:	Date user with "Add" option selected signed the form.