

State of California—Health and Human Services Agency  
Department of Health Care Services



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DIRECTOR



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GOVERNOR

**IF YOU ARE ELIGIBLE FOR FAMILY PACT, MEDI-CAL MAY REIMBURSE YOU FOR  
FAMILY PLANNING AND REPRODUCTIVE HEALTH EXPENSES YOU PAID**

You may be able to be reimbursed for some expenses you paid. The California Department of Health Care Services (DHCS) will assist you in getting your money back if all criteria below are met:

1. You received a Family PACT-covered family planning and reproductive health service during the 3-month period prior to the month you were initially certified for participation in the Family PACT program.
2. You paid for your family planning service, or another person paid for your family planning service on your behalf. You must provide proof that the family planning service was paid for by you or another person and provide an itemized list of services covered by the payment.
3. This form (DHCS 4001) must be certified by a Family PACT provider for you to be eligible for retroactive reimbursement.
4. You do not seek reimbursement for co-payments or excess Share of Cost charges. Reimbursement for valid claims will not exceed the Family PACT rate for the covered service at the time the service was rendered.
5. The medical provider was in California.
6. You are required to provide documentation of medical necessity if prior authorization is required for the service rendered.
7. You were eligible to receive that specific family planning service.
8. The family planning service was a benefit under the Family PACT program.
9. You give the Beneficiary Service Center permission to contact you and/or your Family PACT provider directly.
10. You authorize your medical providers to release necessary records to verify this claim.

Important dates and time frames:

- You must submit your claim within one year of the date of the service. A Claim not submitted within one year of the date of a service will be denied. Only that portion of the claim that is within the allowable timeframe, if any, will be considered for reimbursement.

**To file a claim for reimbursement or for more information call:**

**Beneficiary Service Center - Family PACT, (916) 403-2007 TDD: (916) 635-6491**

**\*\*REMEMBER TO KEEP ALL RECEIPTS FOR THE FAMILY PLANNING AND  
REPRODUCTIVE HEALTH CARE YOU RECEIVED\*\***

The Beneficiary Service Center will review your claim and send you a letter describing the status of your claim. If you disagree with any action taken, you may ask for a state hearing. The letter will tell you how to ask for a state hearing.

**Your Rights:**

You have the right to request a state hearing to review a Beneficiary Service Center decision or action regarding your request for a Beneficiary Reimbursement. You must request a state hearing within 90 days of the date on the Notice of Action that informs you of the decision or action that was mailed to you by the Beneficiary Service Center. Please follow the instructions provided in the Notice of Action to request a state hearing or call the California Department of Social Services' State Hearings Division at 800-952-5253. For TDD service, call 1-800-952-8349. Written requests must be mailed to:

State Hearings Division  
California Department of Social Services  
P.O. Box 944243, Mail Station 19-99  
Sacramento, CA 94244-2430

**Privacy Statement (Civil Code § 1798 et seq.)**

*Civil Code, § 1798.17, and the Federal Privacy Act, 5USC 552a, subdivision (e)(3),  
require this notice be provided when collecting personal or confidential information  
from individuals.*

NPI number:

HAP Identification number:

**HEALTH ACCESS PROGRAMS  
FAMILY PACT PROGRAM  
RETROACTIVE ELIGIBILITY CERTIFICATION (REC)**

***This form is the property of the State of California, Department of Health Care Services, Office of Family Planning, and cannot be changed or altered.*** Please ***print*** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for retroactive eligibility. Providers must keep a copy of this form for three years.

**First name                      Middle name                      Last name                      Suffix (Jr., Sr.)**

<b>Circumstances:</b>	<b>Month/Year:</b>	<b>Month/Year:</b>	<b>Month/Year:</b>
Were you a California resident?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Did you receive Medi-Cal benefits or services?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Did you have a Medi-Cal Benefits Identification Card (BIC)? BIC number: _____ Issue date: _____	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Did you have health care insurance for family planning services? (Private Insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.)	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

***Eligibility Determination:*** Please list all family members (self, spouse, and children) and all taxable income sources. If someone else claims you on their taxes, list everyone claimed and all related taxable income sources. Reportable income includes, but is not limited to: income from employment, self-employment, social security (even if not taxable), passive income (dividends, interest, etc.), pensions and annuities, tips, commissions, spousal support received, and unemployment benefits.

<b>Month/Year</b>	<b>Name(s)</b>	<b>Relationship to You</b>	<b>Age(s)</b>	<b>Source(s) of Income</b>	<b>Taxable Annual Income</b>	<b>Total Taxable Income</b>

**I declare under penalty of perjury under the laws of the state of California that the foregoing information on this form is true and correct. I understand that the giving of false information may make me ineligible for this program. I give the Beneficiary Services Center permission to contact me or my provider for the purpose of processing my claim.**

**THIS IS NOT A CLAIM FORM. YOU MUST FIRST CALL THE BENEFICIARY SERVICE CENTER at (916) 403-2007 to request a claim packet. To be considered for reimbursement you must request, complete and submit a claim form. DO NOT submit this REC form without attaching a COMPLETED CLAIM FORM.**

Signature (or mark) of applicant	Date	Signature of witness to mark or interpreter	Date
Street Address		City	Zip code
Phone number			

**\*\*\*\*FOR PROVIDER USE ONLY\*\*\*\***

	<i>Month/Year:</i>	<i>Month/Year:</i>	<i>Month/Year:</i>
Retroactive Eligible for Family PACT Program	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Medi-Cal client eligible for Family PACT verified	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Retroactive Eligibility Certification is eligible to receive retroactive eligibility under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights on the reverse side. I also certify that the client has received the Notice of Privacy Practices.

Print name	Signature	Date
Street Address	City	Zip code
<b>NPI</b>	Phone Number	

## Language Services Notice

: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-55555 (رقم هاتف الصم والبكم: 711 TTY: [Arabic].

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-541-5555  
TTY : 711 [Chinese]

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-541-5555 TTY: 711 पर कॉल करें। [Hindi]

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-541-5555 TTY: 711 [Hmong]

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-541-5555 TTY: 711 お電話にてご連絡ください。 [Japanese]

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-541-5555 TTY: 711 번으로 전화해 주십시오. [Korean]

ប្រយ័ត្ន: បើសិនអ្នកនិយាយខ្មែរ, សេវាជំនួយភាសាខ្មែរ ឬ មិនគិតលុយ គឺឥតគិតថ្លៃសំបាប់សេវាអាក្រក់។ ចូរ ទូរស័ព្ទ 1-800-541-5555 TTY: 711 [Cambodian]

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸੇਵਾ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-541-5555 TTY: 711 [Punjabi] 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-541-5555 телетайп: 711 [Russian]

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-541-5555 TTY: 711 [Tagalog]

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-541-5555 TTY: 711 [Thai]

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-541-5555 TTY: 711 [Vietnamese]