COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD

THIRD PARTY LIABILITY NOTIFICATION OF TRUST COVER LETTER

Please send this form with proper documentation attached to:
County Medical Services Program, Attention: TPL Unit, 1545 River Park Drive, Suite 435, Sacramento, CA 95815

Name of CMSP Member:	ID#/CIN#	Social Security Number:
Date of Birth:	Date of CMSP Certification Period:	Date of Death:

Name of person completing the form: _____

Title: _____

Phone number: (_____)_____ County: _____

Enclosed are _____ pages.

Date the form sent: _____

Enclosure