

**CLAIMS TRANSMITTAL/CASE RESOLUTION**

**Instructions:** The County Medical Services Program (CMSP) will complete items 1-4 of Section I of the form and forward this form, along with the Claims Detail Report (CDR), to the county for recovery. Upon resolution of this case, the county will complete items 5-11 of Section I of the form and return this form to:

County Medical Services Program  
 Governing Board  
 Attention: Data Section  
 1545 River Park Drive, Suite 435  
 Sacramento, CA 95815

If item 9 below indicates a positive amount, the county must also complete Section II ("Check Handling Slip for CMSP Overpayments") of the form and submit it with a check for the positive amount, made payable to the County Medical Services Program, as instructed to the address listed above. Please include any supporting documentation, which details the cost of collection.

**Section I**

**CONFIDENTIAL**

|                                 |  |
|---------------------------------|--|
| <b>CMSP ONLY</b>                |  |
| 1. County Name                  |  |
| 2. Recipient Name (first, last) |  |
| 3. CIN Number                   |  |
| 4. Claim Total                  |  |
| <b>COUNTY ONLY</b>              |  |
| 5. Overpayment Amount           |  |
| 6. Demand Amount                |  |
| 7. Gross Amount Received        |  |
| 8. Recovery Cost                |  |
| 9. Net Recovered                |  |
| 10. Date of Resolution          |  |
| 11. Reason for Non-Completion   |  |

**Section II**

**CMSP OVERPAYMENT CHECK HANDLING SLIP**

Complete this section when the amount of money recovered in the overpayment process exceeds the cost of recovery. Make the check payable to County Medical Services Program (CMSP).

The attached check in the amount of \$ \_\_\_\_\_ from \_\_\_\_\_  
 County represents the net amount of recovery from a County Medical Services Program (CMSP) overpayment/fraud recovery action.

|                                     |                           |
|-------------------------------------|---------------------------|
| Signature of person completing form | Date                      |
| Title                               | Phone number<br>(       ) |