



CalOptima Health

CALOPTIMA HEALTH CLAIM FOR DAMAGE OR INJURY

INSTRUCTIONS:

1. Answer all sections on both pages of this form completely and attach any additional information as necessary to support your claim.
2. Return this original signed and dated claim form and any attachments **to the attention of the Clerk of the Board** at the address below, in person or by mail.
3. Claims that are not submitted in compliance with the presentation requirements under California Go Section 915(a) will not be processed or handled as government claims.
4. See California Government Code Section 900 et seq. and CalOptima Health Policy AA.1217: Legal Claims and Judicial Review, for more information regarding presenting a claim against CalOptima Health. **Please note the following timeframes:**
 - Claims for death or for injury to person or to personal property must be presented not later than six (6) months after the accrual of the cause of action (Gov. Code Sec. 911.2(a)).
 - Claims relating to any other cause of action must be presented not later than one (1) year after the accrual of the cause of action (Gov. Code Sec. 911.2(a)).

FOR CALOPTIMA HEALTH'S USE ONLY

(Date Claim Received by CalOptima
Health Clerk of the Board)

Received via: ☐ U.S. Mail
☐ Interoffice ☐ Hand Delivery

[ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS]

Name of Claimant

Member Identification Number of Claimant
(if Claimant is a CalOptima Health member)

(_____) _____

Home Address of Claimant

Home Telephone No.

City State Zip

(_____) _____

Business Address of Claimant

Business Telephone No.

City State Zip

ADDRESS TO WHICH CLAIMANT DESIRES NOTICES OR COMMUNICATIONS SENT
REGARDING THIS CLAIM (if different from an address listed above):

WHEN did damage or injury occur? _____

WHERE did damage or injury occur? _____

HOW and under what circumstances did damage or injury occur? _____

WHAT particular action or omission by CalOptima Health, or its employees, caused the alleged damage or injury? (Include names of employees, if known)

WHAT amount do you claim? Include the estimated amount of any prospective loss, insofar as it may be known at the time of the presentation of this claim, together with the basis of computation of the amount claimed.

(Attach copies of all documentation in support of the total amount claimed.)

_____	\$ _____
_____	\$ _____
_____	\$ _____
Total Amount Claimed	\$ _____

If the total amount claimed exceeds \$10,000, indicate whether your claim would be a:

Limited Civil Case (\$25,000 or less) ☐ Unlimited Civil Case (more than \$25,000) ☐

NAMES, addresses and telephone numbers of all persons known to have information about this claim: (Use attachment if necessary)

I HAVE READ THE FOREGOING CLAIM, INCLUDING ATTACHMENTS, IF ANY, AND KNOW THE CONTENTS THEREOF, AND CERTIFY THAT THE SAME IS TRUE ON MY OWN KNOWLEDGE, EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY

INFORMATION AND BELIEF, AND AS TO THOSE MATTERS, I BELIEVE THEM TO BE TRUE. I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Signature of Claimant or Agent
acting on behalf of Claimant

Type or Print Name

Date

Relationship to Claimant

NOTE: Provide all information you wish CalOptima Health to consider and submit original signed claim form and back-up documentation to the Clerk of the Board at the address above on page 1.

WARNING: It is a criminal offense to file a false claim. (See California Penal Code Section 72).