

OPT OUT CANCELLATION FORM

Providers currently receiving monthly e-mail *Medi-Cal Updates* through the Opt Out service may discontinue the electronic version at any time and resume the monthly hard copy (printed) *Medi-Cal Update* service.

Directions: Enter your contact information directly into the form by clicking each of the fields below. However, you must then print and sign the form before mailing it to EDS. An original signature is required; therefore, the form may not be submitted online. If you elect to complete this form by hand, please **print legibly in black ink**.

Provider/Group Name: _____ Provider Number: _____

Contact Name
(if different from above): _____ Phone Number: () _____

Address: _____

PLEASE TYPE OR PRINT LEGIBLY

City	State	Zip Code
		enter the 9-digit code to expedite mail delivery

I would like to receive hard copy (printed) *Medi-Cal Updates* via the postal service. I no longer wish to receive e-mail notification of *Medi-Cal Updates* on the Medi-Cal Web site (www.medi-cal.ca.gov).

Provider/Authorized Provider Representative Signature

Printed Name of Signee

Date

Please allow time for EDS to process the *Opt Out Cancellation Form*.

Mail this completed form to:

General Services Distribution
EDS
P.O. Box 13029
Sacramento, CA 95813-4029

For assistance, contact the Telephone Service Center (TSC) at:

1-800-541-5555



Opt Out
Bulletins E-Mailed

EDS Use Only

Cancelled: _____