HealthPlan OF SAN MATEO
Healthy is for everyone

Change of Address Form

Instructions: Fill out this form for yourself or for any Health Plan of San Mateo (HPSM) member(s) of your household who will be affected by the change of address.

Sign this form on the bottom line. You can mail this form to HPSM, 801 Gateway Blvd., Suite 100, South San Francisco, CA 94080, fax to the appropriate number below or email it to **customersupport@hpsm.org**.

If you need to choose a new primary care provider (PCP), complete the form on the reverse side.

If you have any questions or require assistance with this form, please call HPSM:

CareAdvantage Members:
Phone: **1-866-880-0606**
TTY: **1-800-735-2929** or dial **7-1-1**
Fax: **650-616-2190**

Medi-Cal, San Mateo County ACE and Healthworx (HMO) Members
Phone: **1-800-750-4776** or **650-616-2133**
TTY: **1-800-735-2929** or dial **7-1-1**
Fax: **650-616-8581**

Member Information *(please print)*

Last Name _____ First Name _____ HPSM Member I.D. Number _____

Date of Birth _____ ☐ Male ☐ Female Gender _____ Your Primary Language _____

Home Phone _____ Cell Phone _____

Please check the box for the program you are enrolled in:

☐ CareAdvantage ☐ HealthWorx HMO ☐ Medi-Cal ☐ San Mateo County ACE

Mailing Address *(please print)*

Street Address _____ Apt / Unit # _____

City _____ State _____ Zip Code _____

☐ Check this box if your mailing address and home address are the same.

Home Address *(if different from mailing address)*

Street Address _____ Apt / Unit # _____

City _____ State _____ Zip Code _____

Signature _____ Date _____

See the top of this page for instructions on returning completed forms to HPSM.