

## How to update your address

1. Fill out this form for yourself only. Fill out a separate form for each member of your household affected by the address change.
2. Review the entire form to make sure it is complete and accurate, then sign at the bottom.
3. Submit the form either by mail, email or fax using the contact information for your plan below.

If you have any questions or require assistance, please call HPSM at the phone number for your plan below.

### CareAdvantage members:

Mail: 801 Gateway Blvd., Suite 100  
c/o The CareAdvantage Unit  
South San Francisco, CA 94080

Email: [CareAdvantageSupport@hpsm.org](mailto:CareAdvantageSupport@hpsm.org)

Fax: **650-616-2190**

Phone: **1-866-880-0606**

TTY: **1-800-735-2929** or dial **7-1-1**

### Medi-Cal, San Mateo County ACE and Healthworx (HMO) Members

Mail: 801 Gateway Blvd., Suite 100  
c/o Member Services  
South San Francisco, CA 94080

Email: [MemberServicesSupport@hpsm.org](mailto:MemberServicesSupport@hpsm.org)

Fax: **650-616-8581**

Phone: **1-800-750-4776** or **650-616-2133**

TTY: **1-800-735-2929** or dial **7-1-1**

### Member Information *(please print)*

Last Name	First Name	HPSM Member I.D. Number
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	Male	Female	
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Date of Birth	Gender	Your Primary Language
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Home Phone	Cell Phone
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Please check the box for the program you are enrolled in:

CareAdvantage	HealthWorx HMO	Medi-Cal	San Mateo County ACE
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### Mailing Address *(please print)*

Street Address	Apt / Unit #
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City	State	Zip Code
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Check this box if your mailing address and home address are the same.

### Home Address *(if different from mailing address)*

Street Address	Apt / Unit #
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City	State	Zip Code
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Signature

Date

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