

# Electronic Delivery Confirmation™

**USPS CERTIFIED MAIL™**

Nicolas Hernandez

CA 9

**\$11.40 US POSTAGE**  
FIRST-CLASS IMI  
Feb 11 2026  
Mailed from ZIP 9  
7 OZ FIRST-CLASS MAIL FLATS RATE  
ZONE 4  
11923275



endicia

063S0010937442

**USPS CERTIFIED MAIL**

9 9 9 9

Beneficiary Service Center  
PO BOX 138008  
SACRAMENTO CA 95813-8008



## Reference

USPS #

9 9 9

USPS Mail Class

Certified with Return Receipt (Signature)

USPS Status

Your item was picked up at a postal facility at 5:30 am on February 18, 2026 in SACRAMENTO, CA 95813. Your item was picked up at a postal facility at 5:30 am on **February 18, 2026** in SACRAMENTO, CA 95813.

USPS History

Delivered, Individual Picked Up at Postal Facility, SACRAMENTO, CA 95813, February 18, 2026, 5:30 am  
Delivered to Agent for Final Delivery, SACRAMENTO, CA 95813, February 18, 2026, 5:09 am  
Arrived at Post Office, SACRAMENTO, CA 95813, February 18, 2026, 4:43 am  
Arrived at USPS Facility, SACRAMENTO CA DISTRIBUTION CENTER, February 14, 2026, 11:58 pm  
Arrived at USPS Facility, SANTA CLARITA CA DISTRIBUTION CENTER, February 13, 2026, 9:16 pm  
Accepted at USPS Facility, CA 9, February 13, 2026, 8:01 pm  
Shipping Label Created, CA 9, February 11, 2026, 8:05 pm

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Date Verified: 02/28/2026 (UTC)

February 19, 2026

NICOLAS HERNANDEZ  
[REDACTED]  
[REDACTED], CA 9[REDACTED]

**Re: Medi-Cal Claim Packet Received**

Correspondence Reference Number C-[REDACTED]T2

Dear Client:

This letter is to inform you that the Department of Health Care Services (DHCS) has received your claim for reimbursement (refund) from the Medi-Cal program for medical, pharmacy, and/or dental expenses you paid.

DHCS will contact you if additional information is needed to process your claim. Once your claim is reviewed, you will receive a written notice within 120 calendar days that tells you whether you will be reimbursed (refunded) for the medical, pharmacy, and/or dental services that you included in your claim.

If you have any questions, please call the Beneficiary Services Center at (916) 403- 2007. For TDD/TTY telephone service, please call (866) 784-2595.

Sincerely,

California Department of Health Care Services

Enclosure



February 24, 2026

NICOLAS HERNANDEZ

[REDACTED], CA 9[REDACTED]

**Re: Additional Information Required**

Correspondence Reference Number C-[REDACTED] T2

Dear Client:

This letter is in response to your claim for reimbursement (refund) from the Medi-Cal program for payments you made for medical, pharmacy, and/or dental services. The Department of Health Care Services (DHCS) needs the following information in order to process your request.

To file a claim, you must submit a signed Medi-Cal Claim Form for Beneficiary Reimbursement.

**If you are requesting reimbursement for medical, pharmacy, and/or dental services, your claim form must include:**

- A completed Payee Data Record form (STD 204).
- A copy of your Medi-Cal Beneficiary Identification Card (BIC) or your Health Access Program (HAP) identification card.
- Missing item specific to Medi-Cal - Your Pharmacy claim has been forward to Medi-Cal Rx for further processing.
- Missing item specific to Medi-Cal - There may be additional forms included in your letter package, however, only complete the forms that have been identified in this letter.
- Other: The Payee Data Record Form you provided was invalid as Section 4 was not completed.

DHCS will process your claim when it receives all of the required information. You

