MEDI-CAL CHOICE FORM

My Medi-Cal Choice For Healthy Care

Use this form to join or change health plans. If you need help filling out this form, call 1-800-430-4263.

Mail Completed form to: California Department of Health Care Services • Health Care Options • Box 989009, W. Sacramento, CA 95798-9850.

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE OVALS ⬬ TO INDICATE YOUR CHOICE. SEE BACK FOR EXAMPLE

1) Head of Household Name (First Name, Last Name)

2) Sex ◯ M ◯ F

3) Telephone Number

4) Home Address (House Number, Street, Apartment Number, City, and Zip Code)

Please choose a Health Plan from the list for each member listed. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

5) Applicant's Name (First Name, Last Name)

6) Sex ◯ M ◯ F

6a) Due Date (if pregnant) / /

6b) Social Security Number

HEALTH PLANS

◯ ***I wish to JOIN or change my plan to:***

◯ 304 L.A. Care Health Plan

◯ 352 Health Net Comm Solutions

◯ 000 Regular Medi-Cal (FFS)

Doctor/Clinic Code

Plan Partner Name (see back of choice form)

Enter plan change reason code*.

◯ MO ◯ LA ◯ BC ◯ KA ◯ HN ◯ CF

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INTERNAL USE ONLY

***PLAN CHANGE REASON CODES:**

Code 1: I could not choose the doctor or dentist I wanted
Code 2: The health/dental plan did not meet my needs
Code 3: My doctor/dentist did not meet my needs
Code 4: Too far to go
Code 5: I did not choose this plan
Code 6: Moving out of the county
Code 7: Indian Health Program Exemption
Code 8: Medical/Dental Exemption
Code 9: Other

NOTICE: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services. If I pick Kaiser, I give up my right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a State hearing of any issue, which is subject to the State hearing process.

CHOICE STATEMENT: I/We have made written choice to receive Medi-Cal benefits through the medical plans as I/we have indicated on this form. I/We have read and understand the conditions of this agreement. I/We understand that in order to change my/our current Medi-Cal Health plan, I/we must complete this form.

Head of Household's Signature Date

Other Adult's Signature Date

Other Adult's Signature Date

7254061943

Highly Confidential

DHCS California Department of HealthCareServices

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