

Medi-Cal Managed Care Non-Medical Exemption

Request for Non-Medical Exemption from Plan Enrollment American Indians or Beneficiaries with HIV/AIDS in Coordinated Care Initiative Counties

Dear Medi-Cal Beneficiary: If you are receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you are a qualified individual for this exemption and you want to receive medical services through your choice of facility or provider, you may request to be excused from Medi-Cal Managed Care health plan enrollment in order to receive services through a service facility or provider of your choice.

To be excused from plan enrollment you must have a service facility or provider representative complete this form, certifying that you are or will be receiving services from a service facility or provider of your choice. The facility representative must submit this completed form to Health Care Options.

Dear Service Facility or Provider: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal benefits and that individual is required to enroll in a health plan, completion of this form will enable the individual to receive services through your facility as an alternative to enrollment in a Medi-Cal Managed Care health plan. The exemption form is valid until the individual chooses to enroll in a Medi-Cal Managed Care health plan. This form

may be submitted for beneficiaries who are receiving Medi-Cal services in a Coordinated Care Initiative County and has operating Cal MediConnect health plans and: 1) are American Indian, or 2) have been diagnosed with HIV or AIDS.

Mail completed form to: Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or Fax this form to: (916) 364-0287

If you have any questions regarding this form, please call HCO at 1-844-580-7272; TTY/TDD users, call 1-800-430-7077.

Please Print or Type (Ink Only)

Each area of this non-medical exemption form must be completed or the form will be returned unprocessed.

1. Beneficiary Name:			2. Beneficiary Medi-Cal I.D. Number (BIC)		
Last Name	First Name	M.I.	_____		
3. Name of Service Facility or Provider					

I certify that the information I have provided on this form is correct. I understand that the Department of Health Care Services may audit this form to determine if the information provided is accurate.					
4a. Authorized Signature of Medi-Cal Provider			4b. Date signed		
_____			____/____/____ Month Day Year		
4c. Printed name of Medi-Cal Provider			4d. NPI Number used to bill the Medi-Cal Program for this beneficiary		
Last Name	First Name	M.I.	_____		
5. Telephone number of Medical Provider			6. Fax number of Medical Provider		
(____)____-_____			(____)____-_____		
7. Telephone number of Medical Physician			8. Fax number of Medical Physician		
(____)____-_____			(____)____-_____		