



MEDI-CAL CHOICE FORM

Use this form to join or change health/dental 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

<input type="text"/>	○ M ○ F	<input type="text"/>
1) Head of Household Name (First Name, Last Name)	2) Sex	3) Telephone Number
<input type="text"/>		
4) Home Address (House Number, Street, Apartment Number, City, and Zip Code)		

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

<input type="text"/>	○ M ○ F	<input type="text"/>	<input type="text"/>
5) Applicant's Name (First Name, Last Name)	6) Sex	6a) Due Date (if pregnant)	6b) Social Security Number
<input type="radio"/> <u>I wish to JOIN or change my plan to:</u> <input type="radio"/> 170 KP Cal, LLC <input type="radio"/> 000 Regular Medi-Cal (FFS) <input type="radio"/> 150 Health Net Comm Solutions <input type="radio"/> 190 Anthem Blue Cross Partnrshp <input type="radio"/> 130 Molina Healthcare Partner Doctor/Clinic Code <input type="text"/>		<input type="radio"/> <u>I wish to JOIN or change my plan to:</u> <input type="radio"/> 421 Access Dental Plan <input type="radio"/> 000 Regular Medi-Cal (FFS) <input type="radio"/> 425 Liberty Dental Plan of CA <input type="radio"/> 427 HealthNet of California Dentist/Clinic Code <input type="text"/>	
HEALTH PLANS		DENTAL PLANS	
Enter plan change reason code* <input type="checkbox"/>		Enter plan change reason code* <input type="checkbox"/>	

<input type="text"/>	○ M ○ F	<input type="text"/>	<input type="text"/>
5) Applicant's Name (First Name, Last Name)	6) Sex	6a) Due Date (if pregnant)	6b) Social Security Number
<input type="radio"/> <u>I wish to JOIN or change my plan to:</u> <input type="radio"/> 170 KP Cal, LLC <input type="radio"/> 000 Regular Medi-Cal (FFS) <input type="radio"/> 150 Health Net Comm Solutions <input type="radio"/> 190 Anthem Blue Cross Partnrshp <input type="radio"/> 130 Molina Healthcare Partner Doctor/Clinic Code <input type="text"/>		<input type="radio"/> <u>I wish to JOIN or change my plan to:</u> <input type="radio"/> 421 Access Dental Plan <input type="radio"/> 000 Regular Medi-Cal (FFS) <input type="radio"/> 425 Liberty Dental Plan of CA <input type="radio"/> 427 HealthNet of California Dentist/Clinic Code <input type="text"/>	
HEALTH PLANS		DENTAL PLANS	
Enter plan change reason code* <input type="checkbox"/>		Enter plan change reason code* <input type="checkbox"/>	

<input type="text"/>	○ M ○ F	<input type="text"/>	<input type="text"/>
5) Applicant's Name (First Name, Last Name)	6) Sex	6a) Due Date (if pregnant)	6b) Social Security Number
<input type="radio"/> <u>I wish to JOIN or change my plan to:</u> <input type="radio"/> 170 KP Cal, LLC <input type="radio"/> 000 Regular Medi-Cal (FFS) <input type="radio"/> 150 Health Net Comm Solutions <input type="radio"/> 190 Anthem Blue Cross Partnrshp <input type="radio"/> 130 Molina Healthcare Partner Doctor/Clinic Code <input type="text"/>		<input type="radio"/> <u>I wish to JOIN or change my plan to:</u> <input type="radio"/> 421 Access Dental Plan <input type="radio"/> 000 Regular Medi-Cal (FFS) <input type="radio"/> 425 Liberty Dental Plan of CA <input type="radio"/> 427 HealthNet of California Dentist/Clinic Code <input type="text"/>	
HEALTH PLANS		DENTAL PLANS	
Enter plan change reason code* <input type="checkbox"/>		Enter plan change reason code* <input type="checkbox"/>	

***PLAN CHANGE REASON CODES:**

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



Please use the following example when you fill in the form:

PLEASE PRINT IN CAPITAL LETTERS ONLY.

1	2	3	4	5	6	7	8	9	0	,	A	B	C	D	E	F	G	H
I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	-

PRIVACY STATEMENT

The Department of Health Care Services will keep the information you provide. It is used only to enroll and/or disenroll people that are eligible for Medi-Cal managed care. The laws that allow this are in the Welfare and Institutions Code, Sections 14016.5, 14016.6, 14087.305, 14087.31, 14087.35, 14087.36, 14087.38, 14087.96, 14088, 14089, 14089.5, and 14631, and California Code of Regulations, Section 51085.5. If any information asked for on the choice form is missing, then someone on the form may not be able to join a health plan, get out of a plan, or choose the plan he or she wants.

Only other government agencies that relate to the Medi-Cal program can see the information you provide. The persons listed on the form can look at the files that Medi-Cal keeps on them. However, any information that is being used in an investigation or lawsuit cannot be seen. If you want to see your Medi-Cal file, contact the Department of Health Care Services at the address on the other side of this form.