MEDI-CAL CHOICE FORM

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:***

○ 309 Santa Clara Family H.P.

○ 345 Anthem Blue Cross Partnrshp

○ 000 Regular Medi-Cal (FFS)

Doctor/Clinic Code

Plan Partner Name (see back of choice form)

Enter plan change reason code*. ☐ ○ KA

5) Applicant's Name (First Name, Last Name) | 6) Sex ○ M ○ F | 6a) Due Date (if pregnant) | 6b) Social Security Number

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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

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Highly Confidential

DHCS California Department of HealthCareServices

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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 -

PLAN PARTNER INFORMATION FOR:

309 Santa Clara Family H.P.

KA KP Cal, LLC

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.