MEDI-CAL DENTAL CHOICE FORM

Use this form to join or change a dental plan or return to Regular Medi-Cal. 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 Dental Plan from the list for each member listed. The Dentist/Clinic Codes can be found in the Dental Plan Provider Directory.

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

6) Sex ○ M ○ F

6a) Due Date (if pregnant)

6b) Social Security Number

DENTAL PLANS

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

○ 405 Health Net

○ 409 Access Dental Plan

○ 416 Liberty Dental Plan of CA

○ 000 Regular Medi-Cal (FFS)

Dentist/Clinic Code

Enter plan change reason code*.

DENTAL PLANS

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

6) Sex ○ M ○ F

6b) Social Security Number

DENTAL PLANS

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

○ 405 Health Net

○ 409 Access Dental Plan

○ 416 Liberty Dental Plan of CA

○ 000 Regular Medi-Cal (FFS)

Dentist/Clinic Code

Enter plan change reason code*.

DENTAL PLANS

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

6) Sex ○ M ○ F

6b) Social Security Number

DENTAL PLANS

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

○ 405 Health Net

○ 409 Access Dental Plan

○ 416 Liberty Dental Plan of CA

○ 000 Regular Medi-Cal (FFS)

Dentist/Clinic Code

Enter plan change reason code*.

DENTAL PLANS

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: DO NOT USE
Code 8: DO NOT USE
Code 9: Other

CHOICE STATEMENT: I/We have made written choice to receive Medi-Cal benefits through the 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 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.