

How To Fill Out the Medi-Cal Dental Choice Form

Use the MEDI-CAL DENTAL CHOICE FORM(S) to join or change a dental plan or return to Regular Medi-Cal (Fee-For-Service). You can use each form for up to three family members. You can get more forms by calling Health Care Options at 1-800-430-4263.

Please print clearly, using blue or black ink only. Write in block letters, and completely fill in all areas to indicate your choice. **See the backside of the choice form for an example.**

Head of Household Name

This section is to be completed by the Medi-Cal head of household.

1. HEAD OF HOUSEHOLD NAME
Print your full name
(First and Last Name).

2. SEX
Fill in oval M for male
or F for female.

3. TELEPHONE NUMBER
Write your home area code and
telephone number.

4. HOME ADDRESS
Print your home address including the
House Number, Street, Apartment Number, City
and Zip Code.

MEDI-CAL DENTAL CHOICE FORM
Use this form to join or change a dental plan. 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 3) Telephone Number

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

Choosing a Dental Plan

Before going on with the form, choose a dental plan for each family member. You can choose different plans for each family member. You can also choose different dentists in the same dental plan for each family member. After you have made your dental plan choice, you can complete the Medi-Cal Dental Choice Form.

Join or Change a Dental Plan

Please complete sections for all members who must join or want to change a dental plan.
Parts of this section may already be filled out for you.


5. APPLICANT'S NAME

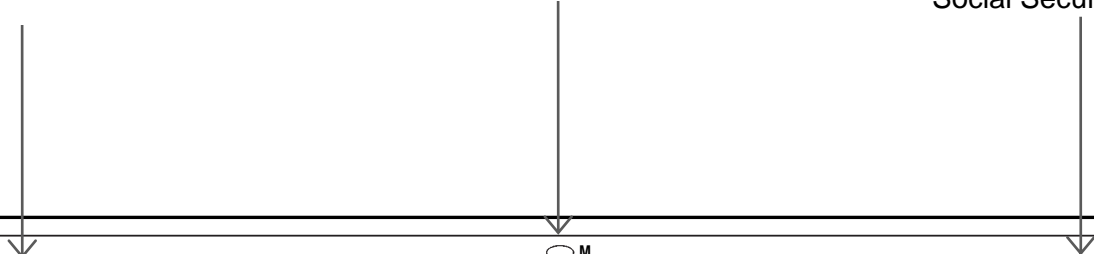
Print the full name
(First and Last Name)
of an individual member of
your family.

6. SEX

Fill in oval M for
male or F for
female.

6b. SOCIAL SECURITY NUMBER

Do nothing if there is a
barcode  in this space.
Otherwise, enter your
Social Security Number.



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

M
 F

6) Social Security Number

I wish to JOIN or change my plan to:

<input type="radio"/> 000 Dental Plan	<input type="radio"/> 000 <i>No Plan Change</i>	
<input type="radio"/> 000 Dental Plan	<input type="radio"/> 000 Dental Plan	
<input type="radio"/> 000 Dental Plan	<input type="radio"/> 000 Dental Plan	
<input type="radio"/> 000 Dental Plan	<input type="radio"/> 000 Dental Plan	
<input type="radio"/> 000 Dental Plan	Dentist/Clinic Code	
<input type="radio"/> 000 Dental Plan		

Enter plan change reason code*.

*** PLAN CHANGE REASON CODES:**

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

Join or Change A Dental Plan

- **Join a Dental Plan:**

Fill in the oval next to “I wish to JOIN or change my plan to:”. Then, fill in the oval for your dental plan choice.

- **Change a Dental Plan:**

Choose a reason for leaving the dental plan from the shaded box called “*PLAN CHANGE REASON CODES” located at the bottom of the form. Write this code number in the box next to “Enter plan change reason code*”.

- **If the “No Plan Change” oval is available:**

Fill in the oval for “No Plan Change” if any member of the family listed on the choice form does not want to change dental plans.

• **Dentist/Clinic Code:**

Write the code number for the dentist or clinic. This information can be found in the Plan Provider Directory. If there is no number, leave this blank.

For example, the code number may be listed in the Provider Directory as:


- **Dentist's Provider #**
- **PCP #**
- **Identification Number (ID)**
- **Doctor I.D. Number**
- **PIN (Provider Identification Number)**
- **Provider 0000 (ex. provider 3322)**
- **# 0000, * 00000 or 00000 (ex. # 3322 above or next to the Dentist's name)**

Completing and Mailing the Form

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

Highly Confidential



SIGNATURE

Make sure that you and any other adults listed on the form SIGN and date the form on the bottom.

If you have questions or need help filling out this form, call Health Care Options at 1-800-430-4263. There are also meetings you can attend to discuss dental plan choices.

DO NOT CALL YOUR ELIGIBILITY WORKER IF YOU HAVE QUESTIONS ABOUT YOUR MEDI-CAL DENTAL CHOICE FORM. Your Eligibility Worker can only help you with questions about your Medi-Cal benefits or eligibility