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.

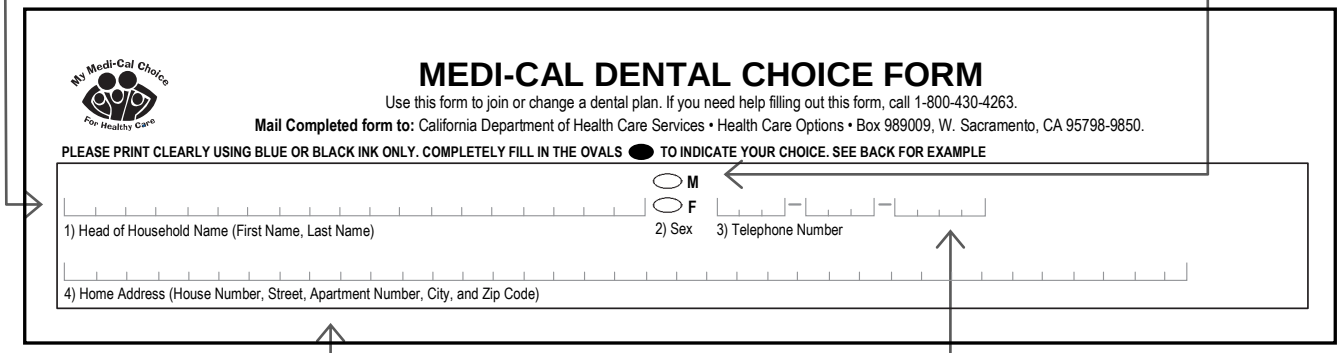
Please print clearly, using blue or black ink only. Write in block letters, and completely fill in all areas to indicate your choice. **See the backside of the choice form for an example.**

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.



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

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

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.

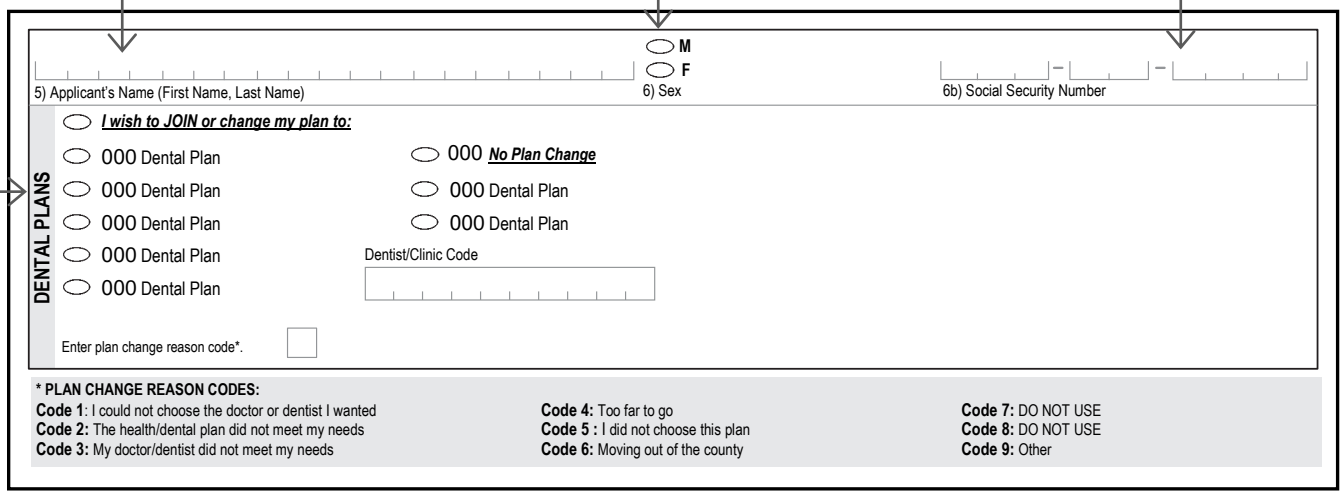
Join or Change a Dental Plan

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.



Join or Change A Dental Plan

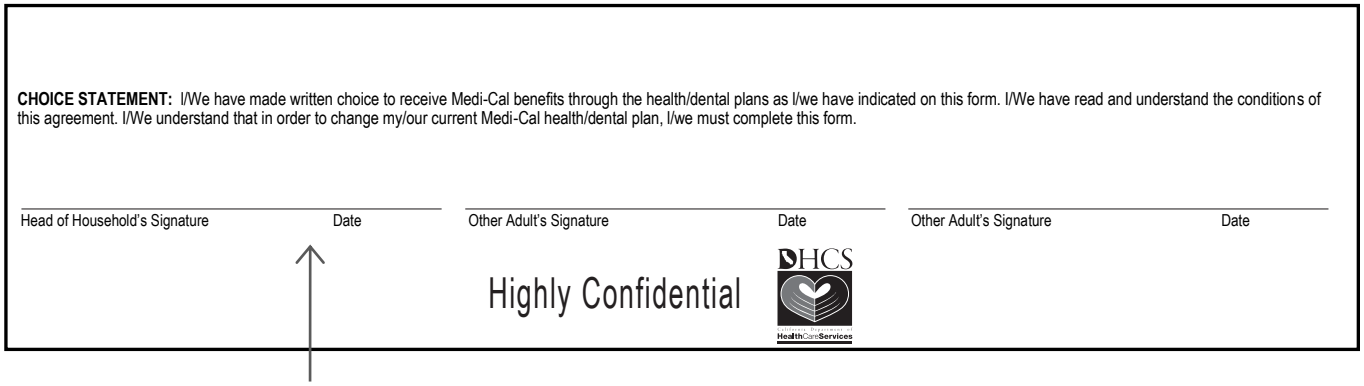
- **Join a Dental Plan:**
  Fill in the oval next to "I wish to JOIN or change my plan to:". Then, fill in the oval for your dental plan choice.

- **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



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 QUESTINS ABOUT YOUR MEDI-CAL DENTAL CHOICE FORM. Your Eligibility Worker can only help you with questions about your Medi-Cal benefits or eligibility