# How to Fill Out the Medi-Cal Choice Form

Use the **MEDI-CAL CHOICE FORM(S)** in this packet to join a health plan or to choose Regular Medi-Cal (Fee-For-Service). Benefits will not change for voluntary beneficiaries who remain in Regular Medi-Cal (Fee-For-Service). Fill out one form for each family member. 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.**

## Lines 1 through 7

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

Use this form to join or change plans. For help, call 1-800-430-4263.
Please print. Fill in the ovals ⬬ to indicate your choice.

1) Head of Household Name (First Name)
2) Last Name
3) Home Address (House Number, Street Name, Apartment Number)
4) City
5) Zip Code
6) Area Code & Phone Number
7) E-mail Address

**1 2 Head of Household**
Print your full name (First and Last Name).

**3 4 5 Home Address**
Print your Home Address including the House Number, Street, Apartment Number, City and Zip Code.

**6 Telephone Number**
Write your home area code and telephone number.

**7 E-mail Address**
Write your E-mail address.

## CHOOSING A HEALTH PLAN

Think about the things that are important to you when you receive health care. You may want to talk to your family, friends, or your current doctor or clinic staff. The material in this packet will help you make a choice. After you have made your health care choice, you can complete the Medi-Cal Choice Form.

# Join or Change a Health Plan

## Lines 8 through 16

*Please complete the Health Plan section for all members who want to join or change a health plan. Parts of this section may already be filled in for you.*

8) Applicant's Name (First Name)
9) Last Name
10) Sex ⬭ Male ⬭ Female
11) Due Date (if pregnant) __/__/__
12) Birth Year
13) Social Security Number __-__-__
14) **I wish to JOIN or change my plan to:**

| | | | |
|---|---|---|---|
| ⬭ XXX | **Medical Health Plan** | ⬭ XXX | **Medical Health Plan** |
| ⬭ XXX | **Medical Health Plan** | ⬭ XXX | **Regular Medi-Cal (FFS)** |
| ⬭ XXX | **Medical Health Plan** | | |

15) Doctor/Clinic Code

Internal Use

16) Fill in the oval next to the reason for changing your plan.

| | |
|---|---|
| ⬭ I could not choose the doctor I wanted | ⬭ Moving out of the county |
| ⬭ The plan did not meet my needs | ⬭ Indian Health Program Exemption |
| ⬭ My doctor did not meet my needs | ⬭ Exempt from a plan |
| ⬭ Too far to go | ⬭ Other |
| ⬭ I did not choose this plan | |

### 8 9 Applicant

Print the full name (First and Last name) of the individual member of your family who must join or wants to change a health plan.

### 10 Sex

Fill in the gender.

### 11 Due Date

The due date is the day the baby is expected to be born (month/day/year). For example, December 2, 2003 would be entered as 12/2/2003.

### 12 Birth Year

List the year the applicant was born.

### 13 Social Security Number

Do nothing if there is a bar code in this space. Otherwise, enter **the applicant's** Social Security Number.

### 14 Join or Change a Health Plan

Fill in the oval next to the health plan you wish to join. If you have selected Regular Medi-Cal (Fee-For-Service), then skip to Completing and Mailing the Form.

### 15 Doctor/Clinic Code

**(For Medi-Cal Health Plans ONLY)** Enter the doctor or clinic code. This information can be found in the Provider Directory. If there is no number, leave this blank.

*Codes may be listed as:*

- Doctor's Code
- Clinic Code
- PCP #
- Identification Number (ID)
- Doctor I.D. Number
- PIN (Provider Identification Number)
- Provider 0000 (ex. Provider 3322)

### 16 To Change a Plan

Fill in the oval next to the reason why you are changing your plan. If your reason is not listed, fill in the oval next to "Other".

## Line 17 – Program of All-Inclusive Care for the Elderly (PACE)

*You may qualify for PACE. Please fill in the oval next to the PACE plan you wish to join. If you do not qualify for PACE, you will get your care through the plan selected in section 14.*

17) **Program of All-Inclusive Care for the Elderly (PACE):** You may qualify for PACE (see instructions). If you want to enroll with a PACE plan, fill out this option **in addition to section 14**. If you do not qualify for PACE, you will get your care through the plan selected in Section 14.

- ⬭ XXX **PACE Plan**
- ⬭ XXX **PACE Plan**
- ⬭ XXX **PACE Plan**
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- ⬭ XXX **PACE Plan**
- ⬭ XXX **PACE Plan**

# Completing and Mailing the Choice Form

## Sign and Date

Make sure the form is signed by the applicant, or representative.

**Choice Statement:** I/We have made written choice to receive Medi-Cal benefits through the plans as I/we have indicated on this form. I/We have read and understand the conditions of this agreement on **both sides**. I/We understand that in order to change my/our current Medi-Cal plan, I/we must complete this form.

Head of Household or Authorized Representative Signature ____________ Date ____________

### Sign and Date

Print the full name (First and Last name) of the individual member of your family who must join or wants to change a health plan.

# You're Done!

**Use the envelope included in this packet to mail the form. It does not need a stamp. Keep the last copy of the form for your records.**

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 health plan choices. See the Health Care Options Presentation Schedule in this packet, if available.

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