Health Plan Choice Form

Use this form to join or change a health plan. For FREE help with this form, contact Health Care Options at 1-844-580-7272. Mail completed form to California Department of Health Care Services, Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850. Please print clearly using blue or black ink.

STEP 1: Tell us about yourself:

First Name _____ Last Name _____

Address _____

City _____ Zip Code _____ (Area Code) Phone Number ___-___-____

___/___/_____ Date of Birth ___/___/_____ Due Date (if pregnant)

Sex: ◯ Male ◯ Female

___-___-____ Social Security Number

STEP 2: Choose your health plan:

CHOICE A **OR** **CHOICE B**

Combine my Medicare and Medi-Cal benefits in one plan. Choose one of these Cal MediConnect plans:

- ◯ **805 Health Net**
- ◯ **804 CommuniCare Advantage**
- ◯ **806 Molina Dual Options**
- ◯ **803 Blue Shield Promise**

Doctor/Clinic Code: _____ (optional)

Keep my Medicare separate AND choose a Medi-Cal Managed Care plan. Choose one of these Medi-Cal Managed Care plans to get your Medi-Cal benefits:

- ◯ **029 Community Hlth Grp Partner**
- ◯ **167 Blue Shield Promise**
- ◯ **079 KP Cal, LLC**
- ◯ **131 Molina Healthcare Partner**
- ◯ **068 Health Net Comm Solutions**

Doctor/Clinic Code: _____ (optional)

Program of the All-Inclusive Care for the Elderly (PACE): You may qualify for PACE (see instructions). If you want to get your Medicare and Medi-Cal benefits combined in a PACE plan, fill out this option **in addition to Choice A or B.** If you do not qualify, you will get your care through the Choice A or Choice B plan that you chose above in Step 2.

PACE Plan:

- ◯ **057 St. Paul's PACE**
- ◯ **065 San Diego PACE**
- ◯ **069 Gary and Mary West PACE**
- ◯ **073 Family Health Center**

STEP 3: Read the important information on the back before signing. I understand that by filling out and signing this form, I am choosing how to get my health care.

Applicant's Signature _____ Date _____ OR Authorized Representative Signature (if any) _____ Date _____

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, Section 10416.5, 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.