Mail form back to: California Department of Health Care Services
P.O. Box 989009 • W. Sacramento, CA 95798-9850

Medi-Cal Choice Form

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

Choose a plan and a plan partner from the list below. See the provider directory for Doctor/Clinic Codes.

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:**

- ◯ **304 L.A. Care Health Plan**
  - ◯ BC Anthem Blue Cross Partnrshp
  - ◯ BL Blue Shield Promise
  - ◯ KA KP Cal, LLC
  - ◯ LA L.A. Care Health Plan
- ◯ **352 Health Net Comm Solutions**
  - ◯ HN Health Net Comm Solutions
  - ◯ MO Molina Healthcare Partner
- ◯ **000 Regular MediCal (FFS)**

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

Notice: I have read the plan description. I understand that Kaiser requires the use of binding neutral arbitration to resolve certain disputes. This includes disputes about whether the right medical treatment was provided (called medical malpractice) and other disputes relating to benefits or the delivery of services. If I pick Kaiser, I give up my right to a jury or court trial for those certain disputes. I also agree to use binding neutral arbitration to resolve those certain disputes. I do not give up my right to a State hearing of any issue, which is subject to the State hearing process.

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. I/We understand that in order to change my/our current Medi-Cal plan, I/we must complete this form.

HCOOMBA

Head of Household or Authorized Representative Signature Date

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, 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.