STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
GRAY DAVIS, *Governor*

DEPARTMENT OF HEALTH SERVICES
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(916) 654-8076

January 31, 2001

All County Information Letter No.: I 01-01

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Outstationed Eligibility Workers Coordinators
All County Public Health Directors
All County Mental Health Directors
All County Health Executives Association of California

AMENDED REGULATIONS FOR ENROLLMENT AND DISENROLLMENT FOR TWO PLAN MODEL PLANS

PURPOSE

The purpose of this letter is to inform counties that amended regulations related to enrollment in and disenrollment from two-plan model Medi-Cal managed care plans (MCPs) were filed with the Secretary of State on December 19, 2000. These amended regulations were filed under the Department's emergency rulemaking authority and became effective December 29, 2000.

BACKGROUND

The Department is amending the following sections in Title 22 of the California Code of Regulations in order to update the enrollment and disenrollment criteria for MCP members, improve the clarity of various aspects of enrollment and disenrollment process, and provide increased control over the granting of exemptions to plan enrollment:

- Section 53845 Enrollment Criteria
- Section 53881 Marketing and Member Materials
- Section 53886 Health Care Options Presentation
- Section 53887 Alternative to Plan Enrollment
- Section 53888 Enrollment/Disenrollment Form
- Section 53889 Enrollment/Disenrollment Form Processing
- Section 53891 Disenrollment of Members
- Section 53892 Problem Resolution Process for Members
- Section 53895 Information to New Members

Many of the amendments to these regulations simply update the regulations to reflect current program operation. However, an important focus of these amendments is updating and strengthening the process for granting exemptions to plan enrollment, whether for medical or non-medical reasons.

In mid-1999 the Department noted that the number of requests for medical exemptions had dramatically increased. Medi-Cal Managed Care Division (MMCD) staff became increasingly concerned about the possibility of fraud and abuse in the medical exemption request process. Subsequent investigation by the Department's Audits and Investigations Program revealed significant problems with virtually all of over 10,000 exemptions, such as no verification of the complex medical conditions in patient charts, beneficiaries not receiving care from the physicians requesting exemptions, and beneficiaries not knowing that an exemption had been submitted on their behalf. As a result of fraudulent medical exemptions, the State not only has paid more for fee-for-service claims than would have been paid if these beneficiaries had been enrolled in Medi-Cal MCPs, but also has in some cases paid for health care that was never provided.

These regulatory changes will help ensure that exemptions from enrollment in Medi-Cal MCPs will be granted only when appropriate and that dollars allocated for health care for Medi-Cal beneficiaries – whether through Medi-Cal managed care or the fee-for-service program – will be used for that purpose. The amendments also provide many critical improvements to the enrollment and disenrollment regulations, making it easier for beneficiaries, legal representatives and advocates, and healthcare providers to understand the criteria and timelines for enrollment in and disenrollment from Medi-Cal MCPs in two-plan model counties.

FURTHER DISCUSSION

This section of the All County Information Letter highlights the regulatory changes contained in each amended section of Title 22. However, county personnel should not rely on this summary for a thorough understanding of these amended regulations, but should also review the entire regulatory proposal. The proposal contains not only the full text of the amended regulations, but also a detailed discussion of the reason for every change, both substantive and non-substantive.

Section 53845, "Enrollment Criteria"

This section has been updated to correctly list the Medi-Cal programs designated for either mandatory or voluntary enrollment of beneficiaries in those programs in Medi-Cal MCPs in two-plan model counties. This update includes the recent addition of children in the Percent of Poverty program to the mandatory enrollment category. Note that these changes have already been implemented for Medi-Cal MCPs in both two-plan model and Geographic Managed Care (GMC) counties, so these amendments will not result in any aid code changes in plan contracts.

Section 53881, "Marketing and Member Materials"

The amendments to this section are generally technical language changes or updated cross-references. Plan contracts already specify the same requirements now reflected in this section.

Section 53886, "Health Care Options Presentation"

The amendments to this section are generally technical language changes or updated cross-references to other sections. Plan contracts already specify the same requirements now reflected in this section.

Section 53887, "Alternative to Plan Enrollment"

This section has been completely rewritten in order to more clearly explain all the situations that qualify a beneficiary (in a mandatory enrollment category) for exemption from enrollment in a Medi-Cal MCP. To qualify for an exemption from plan enrollment, the beneficiary must satisfy one of the following conditions:

- Be an American Indian who has been accepted to receive healthcare services from an Indian Health Service facility on a fee-for-service basis. (This is usually referred to as an "Indian Health Program exemption.")

- Be under treatment for a complex medical condition from a Medi-Cal provider who is not contracted with either Medi-Cal MCP in the beneficiary's residence county. (This is usually referred to as a "medical exemption" and is granted in order to prevent any interruption of care for a beneficiary with a complex medical condition until such time when the beneficiary has completed treatment or may safely be transitioned to a new provider.)

Section 53887 now lists the specific medical conditions that qualify a beneficiary for a medical exemption:

- Pregnancy
- Under evaluation for organ transplant or approved for and awaiting transplant.
- Receiving chronic renal dialysis treatment.
- HIV positive or diagnosed with AIDS.
- Diagnosed with cancer and currently receiving a course of accepted therapy (such as chemotherapy or radiation).
- Approved for a major surgical procedure by the Medi-Cal Fee-For-Service (FFS) program and awaiting surgery or immediately post-operative.
- Has another complex and/or progressive disorder not listed above, such as cardiomyopathy or amyotrophic lateral sclerosis that is already under treatment.
- Is enrolled in a Medi-Cal waiver program that allows the beneficiary to receive sub-acute, acute, intermediate or skilled nursing care at home rather than as an in-patient. (This is known as a "waiver exemption" and currently includes four Medi-Cal waiver programs – AIDS Waiver, Model Waiver, In-Home Medical Care Waiver, and Skilled Nursing Facility Waiver.)

- Is enrolled in a Medi-Cal pilot project.

This section also specifies that medical exemptions cannot be approved for a beneficiary who has:

- Been a member of either plan for more than 90 days.
- Has a current Medi-Cal provider who is contracted with either plan.
- Began treatment or was scheduled to begin treatment after the date of plan enrollment.

This amended section also specifies that medical exemptions will be granted for up to 12 months, except those granted due to pregnancy which are granted through delivery and 90 days post-partum. An extension to a 12-month medical exemption can be requested, but no earlier than 11 months after the starting date of the current exemption.

The following new exemption request forms (enclosed) are incorporated by reference in this amended section and are available through the Health Care Options (HCO) Program:

- "Request for Medical Exemption from Plan Enrollment" (HCO Form 7101, dated June 2000)

- "Request for Non-Medical Exemption from Plan Enrolment" (HCO Form 7102, dated October 2000). This form is used for Indian Health Program and Waiver Program exemptions.

This amended section also specifies that the HCO Program approves or disapproves exemption requests and that the Department may at its discretion verify the "complexity, validity, and status" of the beneficiary's medical condition and verify that the provider is not contracted with a plan. The HCO Program or the Department may revoke approved exemptions if a provider fails to cooperate with the verification of the beneficiary's medical condition or the Department determines that:

- The approval was based on false or misleading information.
- The medical condition was not complex.
- Treatment for the medical condition has been completed.
- The requesting provider has not been providing services to the beneficiary.

Section 53888, "Enrollment/Disenrollment Form"

This section now specifies that Medi-Cal MCPs must make the combined enrollment/disenrollment form available through their member services departments and that the form must be mailed within three working days of the plan receiving a telephone or written request for a form. Other amendments to this section were non-substantive language changes made for clarity and consistency.

Section 53889, "Enrollment/Disenrollment Form Processing"

This section has been completely rewritten in order to more clearly explain the following:

- Manner in which enrollment and disenrollment requests are to be submitted. An eligible beneficiary shall submit an enrollment or disenrollment request on an original, signed enrollment/disenrollment form to the Health Care Options Program by mail or in person at department-approved Health Care Options Program sites. Expedited disenrollment requests may also be submitted by facsimile. An eligible beneficiary also may request expedited disenrollment over the telephone from the Health Care Options Program.

- Information that must be provided on the enrollment/disenrollment form. These include: first and last name of the beneficiary; sex; date of birth; Social Security Number; Medi-Cal number; complete mailing address; telephone number, if available; plan choice, if requesting enrollment; name and address of doctor or clinic beneficiary is choosing as primary care provider; language of the beneficiary; and the reason for disenrolling, if requesting disenrollment.

- Processing timelines for completed enrollment and disenrollment requests. Fully completed enrollment/disenrollment forms with all required supporting documentation shall be processed within two working days if the request meets the conditions for plan disenrollment. Beneficiaries shall be notified of approval or disapproval within seven working days of receipt of the request.

- The authorized individuals who may submit enrollment and disenrollment requests on behalf of beneficiaries. These include: persons with legal authority to act on the beneficiaries behalf; Department staff responsible for the administration of the Two-Plan Model Program and Health Care Options staff; Two-Plan Model Program contractors; Case managers, physicians or medical staff in home and community-based services waiver programs; and Care coordinators at Regional Center for the Developmentally Disabled.

- Effective dates for enrollment and both regular and expedited disenrollment. Enrollment requests and non-expedited disenrollment requests will be effective either the first day of the first month, or the first day of the second month, following the month in which the request is processed, based on whether the request was processed before or after the monthly update to Medi-Cal Eligibility Data System (MEDS). Expedited disenrollment requests shall be effective on the first day of the month in which the request is processed.

- Reasons for which expedited disenrollment may be granted. These include: the beneficiary is an American Indian, is receiving services under the Foster Care or Adoption Assistance Program, has a complex medical condition, is enrolled in a Medi-Cal waiver program, is participating in a pilot project, was incorrectly assigned to a plan, as well as a number of other reasons. Each of the reasons includes the documentation required to be submitted with the request.

Section 53891, "Disenrollment of Members"

This section has been amended to update the list of reasons for which disenrollment can be requested, as follows:

- Eligibility for Medi-Cal enrollment is terminated
- Incorrectly assigned to a plan not of the beneficiary's choosing
- Plan merger or reorganization
- Change of residence to outside the plan's service area
- Any reason, made not during restricted disenrollment period
- For good cause, as defined, during restricted disenrollment period
- Meets criteria set forth in Section 53887
- Meets criteria for expedited disenrollment as set forth in Section 53889
- Obtains other health coverage, as defined.

Section 53892, "Problem Resolution Process for Members"

This section has been amended primarily to add further clarity to provisions related to how the HCO Program must assist beneficiaries with problems related to enrollment and disenrollment. The primary changes are as follows:

- The regulation now specifies that plan members may request assistance from the HCO Program by telephone, fax, in writing or in person.

- The regulation specifies that, when the member's problem cannot be resolved by the HCO Program, the member must be referred to not only the plan's problem resolution process and the Medi-Cal Managed Care Office of the Ombudsman, but also to the Department of Managed Health Care's Office of Patient Advocate.

Section 53895, "Information to New Members"

This section has been updated to reflect information that Medi-Cal MCPs are already required, by statute and by contract, to provide to new members. Plan new member materials that have been approved by the Department will already be in compliance with this amended regulation.

Effective Date of New Regulations and Exemption Request Forms

The regulatory proposal was filed with the Secretary of State on December 19, 2000, and became effective December 29, 2000 pursuant to the Department's emergency regulatory authority. The amended regulations were published in the California Notice Register on December 29, 2000.

The HCO Program began placing both the new Medical Exemption Form and the new Non-Medical Exemption Form in Enrollment Packets on January 1, 2001. Also, as of that date the HCO Program will have these forms available to fax or mail to providers or enrollees. It is anticipated that the HCO Program will only accept the old exemption forms until February 1, 2001.

Relationship of New Regulations to Enrollment and Disenrollment in GMC Counties

As previously noted, most of the provisions in these amended regulations are already in effect in Two-Plan Model counties because many of the amendments reflect program changes already in place. This is also true with respect to GMC counties, and in nearly every aspect the Two-Plan Model enrollment/disenrollment regulations reflect rules which are applicable to current procedures in GMC counties. The one exception is that GMC counties are not able at this time to deny exemption requests on the basis that the member has been in the plan for over 90 days. The Department plans to amend the GMC enrollment/disenrollment regulations to mirror the Two Plan Model enrollment/disenrollment regulations during the 2001 calendar year.

Public Comment Period

Following the publication in the California Notice Register on December 29, 2000, there is a 45-day Written Comment Period, during which the counties, or any member of the public, may comment upon the regulatory proposal. All comments, however, are required to be in writing. Any concerns or problems related to the regulatory amendments should not be discussed with Department employees.

If you have any questions regarding the amended regulations, please contact Mary Menz, Chief of the Policy and Contracts Section, MMCD, at (916) 657-3033, or Mark Otto, Policy Analyst, at (916) 657-0676. Thank you for your attention to this matter.

ORIGINAL SIGNED BY
RICHARD BRANTINGHAM for

Glenda Arellano
Acting Chief
Medi-Cal Eligibility Branch

Enclosure

State of California – Health and Human Services Agency | Department of Health Services

REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

Each area of the Request For Exemption From Plan Enrollment form must be completed.
If not, the medical exemption will be denied – **Please Print or Type (Ink Only)**

To Be Completed and Signed By Beneficiary
Part I

1. Name: (Please Print) Last Name / First Name / M.I.		2. Social Security Number: ___-___-____
3. Date of Birth: ___/___/___ Month / Day / Year	4. Check One: ☐ Female ☐ Male	5. Medi-Cal ID Number:
6a. Are you a member of a health Plan? ☐ Yes (go to box 6b) ☐ No (go to box 7a)	6b. Plan Name:	6c. Plan Membership Number:
7a. Is someone other than the beneficiary completing this section? ☐ Yes (go to box 7b) ☐ No (go to box 8)	7b. If yes, please provide the following information: Print Name / Relationship / Phone Number	

8. I am requesting that Dr. _____ (Name of Doctor) send in a request for a Medi-Cal Managed Care **medical exemption** for me.

9. Beneficiary's Signature: Signature of Beneficiary or Parent of Beneficiary if a minor child	10. Date Signed: ___/___/___ Month / Day / Year

This information is requested by the Department of Health Services, Medi-Cal Managed Care Division, under Title 22, California Code of Regulations, Sections 53887 or 53923.5, in order to comply with requirements of continuing with Fee-for-Service medical care. Completion of this form is mandatory for an exemption. Not completing this form could result in enrollment in a Managed Care health plan. **For help with this form, please call Health Care Options at (800) 430-4263. This call is free.**

Physician's Certification For Medical Exemption
Part II

The Beneficiary's rendering physician MUST fill out AND SIGN this section.

For State Use Only — Approved: ☐ Denied: ☐ Deferred: ☐ Initials: _____ Date: _____

11. Date you started treating beneficiary for one of the conditions listed below in box 13: ___/___/___ Month / Day / Year	12. Estimated date of completion of treatment or therapy for condition requiring exemption: ___/___/___ Month / Day / Year

For State Use Only	13. Please check the following as appropriate (ICD-9-CM code must be included in column 14 at right, or the exemption will be considered incomplete and returned.)	14. ICD-9 Codes
P	☐ A. Pregnant and currently under your care for the pregnancy. Due Date _____	
F	☐ B. HIV+ or has been diagnosed with AIDS	1. 2.
D	☐ C. Receiving chronic renal dialysis treatment under your supervision	1. 2.
E	☐ D. Undergoing one of three transplant classifications (see item 13-D on page 4) Classification: _____ Medi-Cal designated transplant center: _____	1. 2.

INSTRUCTIONS FOR COMPLETING REQUEST FOR MEDICAL EXEMPTION FROM PLAN ENROLLMENT

PART I – To Be Completed and Signed By Beneficiary

Dear Medi-Cal Beneficiary: You and/or your family is now or may soon be required to receive your health care through a Medi-Cal Managed Care health plan. You may be seeing a doctor who is not part of a health plan. If you want to keep seeing this doctor, you may qualify for what is called a **medical exemption.** To receive a **medical exemption,** you must be seeing your doctor for something serious, and your doctor must NOT be a part of a health plan in the county where you live.

If you want to ask for a **medical exemption,** you must fill out Part I of this form. Please sign it and give it to your doctor. Your doctor will fill out and sign Part II of this form. If your request for a **medical exemption** is approved, you will NOT have to join a Medi-Cal Managed Care health plan for the time being. You can remain on regular Medi-Cal (non-managed care) and keep seeing your current doctor for up to 12 months. (In some cases, the exemption will be for fewer months. Your doctor will decide this.) If you need another medical exemption after your exemption period is over, you and your doctor must fill out and sign a new exemption form.

All information in this medical exemption form will be kept confidential. This information will only be used by the Medi-Cal program, its employees, and contractors.

If you have any questions regarding this form, please call Health Care Options at (800) 430-4263.

INSTRUCCIONES PARA COMPLETAR LA CERTIFICACION DE EXENCION DE ATENCION MEDICA DE LOS PLANES ADMINISTRADOS DE MEDI-CAL

Primera Parte - Para Ser Completado y Firmado Por el Benificiario.

Estimado Benificiario de Medi-Cal : Usted o su familia estan ahora o pueden requerirse que pronto recivan su cuidado de salud a través de un plan de Medi-Cal por Managed Care. Usted puede estar viendo a un doctor que no es parte de un plan de salud. Si usted quiere seguir viendo a este doctor, usted puede calificar para lo que se llama una exención médica. Al recievir una exención médica, usted debe estar viendo a su doctor para algo serio, y su doctor no debe de participar en uno de los planes de Managed Care en el condado donde usted vive.

Si usted quiere pedir una exención médica, usted debe completar la primera parte de esta forma. Por favor firmelo y déselo a su doctor. Su doctor completara la segunda parte de esta forma. Si su peticion para una exención médica es aprovada, usted no tendrá que afiliarse en un plan de Medi-Cal Managed Care por el momento. Usted puede permanecer en Medi-Cal regular (sin plan de salud) y seguir viendo a su actual doctor hasta por 12 meses. (En algunos casos, la exención sera por menos meses. Su doctor decidirá esto.) Si usted necesita otra exención médica después de que su periodo de la exención haya terminado, usted y su doctor deben completar y firmar una nueva forma de exención.

Nos gustaria informarle que toda la información en esta forma de la exención médica se mantendra confidencial. Esta información sólo será usada por el programa de Medi-Cal, sus empleados, y contratistas.

Para mas informacion por favor llame a Health Care Options al (800) 430-3003 esta llamada es completamente gratis.

Part II Continued

For state use only		14. ICD-9 Codes
C	☐ E. Undergoing one of two cancer classifications (see item 13-E on the reverse side). Classification: _____ Type of Therapy: _____	1. 2.
G	☐ F. Has been approved for and is awaiting a major surgical procedure (see item 13-F on the reverse side). CPT code(s) for pending procedure(s): _____	1. 2.
A	☐ G. Has a complex neurological disorder, such as multiple sclerosis	1. 2.
B	☐ H. Has a complex hematological disorder, such as hemophilia or sickle cell disease	1. 2.
M	☐ I. Has other complex and/or progressive disorder not covered above which requires ongoing medical supervision (See item 13-I on the reverse side). Describe treatment: _____	1. 2.

Please note that chronic disorders, such as asthma and diabetes, do not generally constitute grounds for approval as a medical exemption. Providers who believe that the severity of such a condition, or any other condition or combination of conditions, is/are sufficient to require a medical exemption should attach to this form additional medical documentation to establish the necessity for an exemption. Please include the Beneficiary's Medi-Cal identification number and Social Security Number on each page of medical documentation submitted.

15. Beneficiary's Social Security Number

___ ___ ___ - ___ ___ - ___ ___ ___ ___

16. Are you affiliated with any Medi-Cal Managed Care health plan(s) in the Beneficiary's county of residence?

☐ Yes _____
Print the name of health plan

☐ No

17. Physician Medi-Cal Provider Number used to bill the Medi-Cal Program for this beneficiary:

18. Medi-Cal Provider:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

19. Medi-Cal Billing Information: (If different from box 18 above.)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

I have read this form and certify that the information I have provided on this form is correct. I also understand that the Department of Health Services may audit this form to determine if I am affiliated with a Medi-Cal Managed Care health plan(s) and/or to determine whether the Medi-Cal beneficiary's listed medical condition constitutes grounds for a medical exemption.

20. Rendering Physician's Medical License Number:

21. If you are NOT affiliated with any Medi-Cal Managed Care health plan(s) in the Beneficiary's county of residence, you MUST complete this box. If you are affiliated with any Medi-Cal Managed Care health plan(s) in the Beneficiary's county of residence, please make sure boxes 18 and 19 are complete.

Rendering Physician's Phone number: _____ FAX: _____

22. Signature: (No Stamp) _____
(Authorized Rendering Medical Physician)

23. Date Signed: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

MAIL COMPLETED FORM to: Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or FAX this form to:
(916) 364-0287

PART II – To Be Completed and Signed By Beneficiary's Rendering Physician

Dear Medi-Cal Physician: If you are currently providing medical services to the Medi-Cal beneficiary identified in Part I and who has one of the conditions or reasons for a medical exemption listed in Box 13 of this page AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual. The beneficiary must request a medical exemption, and you and the beneficiary must fill out this form, sign it, and mail or fax it (Part I and Part II) to the Health Care Options office (see mailing address and fax number at the bottom of Part II). Please refer to Title 22, California Code of Regulations, Sections 53887 or 53923.5, for additional information concerning requirements for medical exemptions.

This exemption is valid until the date you indicate the individual will be stabilized enough to allow enrollment in a Medi-Cal Managed Care health plan or the condition is resolved. An exemption can be requested for a maximum of 12 months. An extension may be requested at the end of 12 months by submitting a new exemption form.

Instructions for completing Boxes 13-D through 13-I (and 14):

Item 13-D

Please list on the line provided which of the following transplant situations is relevant. Please specify the Medi-Cal designated transplant center involved in the evaluation, transplant procedure or current follow-up. Please specify ICD-9 code for organ transplanted/to be transplanted and any codes for complications in box 14. *(Please note: this exemption does not apply to beneficiaries who are medically stable on post-transplant therapy.)*

Transplant classifications:

- Beneficiary is under active evaluation for the need for an organ transplant
- Beneficiary has been approved for and is awaiting an organ transplant
- Beneficiary has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant performed.

Item 13-E

The type of therapy must be described on the line provided, and both the start date and the expected duration of therapy must be listed in boxes 11 and 12. *Beneficiaries in long-term remission without signs of disease or who are classified as "cured" are not eligible for medical exemption.*

Cancer classifications:

- Beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer
- Beneficiary has been approved for such therapy and is awaiting initiation of approved therapy

Item 13-F

Please check this item if beneficiary has been approved for and is awaiting a major surgical procedure, **including surgery for cancer.**

List both ICD-9 (in box 14) and appropriate CPT code(s) for pending procedure(s) on the line provided. If beneficiary is immediately post-operative, estimate duration of time necessary for recovery under your supervision in box 12.

Item 13-I (and all box 14 ICD codes)

The ICD-9 code must be listed in box 14, and the treatment must be stated on the line provided.
Please check this item if beneficiary has a complex and/or progressive disorder not covered above which requires ongoing medical supervision, such as:

- Cardiomyopathy
- Amyotrophic lateral sclerosis and/or has been approved for or is receiving ongoing complex medical treatment for the disorder, the administration of which cannot be interrupted

REQUEST FOR NON-MEDICAL EXEMPTION FROM PLAN ENROLLMENT

(For use with the Indian Health and Medi-Cal Waiver Programs)

A. INDIAN HEALTH PROGRAM EXEMPTION

Each area of the Indian Health Program Exemption form must be completed or the form will be returned unprocessed.

Please Print or Type (Ink Only)

Dear Indian Health Service Facility: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal benefits and that individual is required to enroll in a health plan, completion of this form will enable the individual to receive services through your facility as an alternative to enrollment in a Medi-Cal Managed Care health plan. The Indian Health Exemption is valid until the individual chooses to enroll in a Medi-Cal managed Care health plan.

1. Beneficiary Name Last Name First Name M.I.	2. Beneficiary Medi-Cal I.D. Number (BIC) _ _ _ _ _ _ _ _ _ _ _ _
3. Name of Indian Health Facility	
I certify that the information I have provided on this form is correct. I understand that the Department of Health Services may audit this form to determine if the information provided is accurate.	
4a. Authorized Signature of IHS Provider	4b. Date Signed Month Day Year
4c. Printed Name of IHS Provider Last Name First Name M.I.	4d. Medi-Cal Provider Number **used to bill the Medi-Cal Program for this beneficiary.** _ _ _ _ _ _ _ _ _ _ _ _
5. Telephone Number of IHS Provider (_ _ _) _ _ _ - _ _ _ _	6. Fax Number of IHS Provider (_ _ _) _ _ _ - _ _ _ _

B. MEDI-CAL WAIVER PROGRAM EXEMPTION

Each area of the Medi-Cal Waiver Program Exemption form must be completed or the form will be returned unprocessed.

Please Print or Type (Ink Only)

Dear Medi-Cal Physician: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal Waiver Program benefits, please complete this portion of the form.

1. Beneficiary Name Last Name First Name M.I.	2. Beneficiary Medi-Cal I.D. Number (BIC) _ _ _ _ _ _ _ _ _ _ _ _
3. Medi-Cal Provider Number _ _ _ _ _ _ _ _ _ _ _ _	4. Medi-Cal Waiver Program: u. ☐ AIDS Waiver Program w. ☐ In-Home Medical Care (IHMC) Waiver Program v. ☐ Model Waiver Program y. ☐ Skilled Nursing Facility (SNF) Waiver Program
I certify that the information I have provided on this form is correct. I understand that the Department of Health Services may audit this form to determine if the information provided is accurate.	
5. Authorized Signature of Medi-Cal Physician	6. Date Signed Month Day Year
7. Printed Name of Medi-Cal Physician Last Name First Name M.I.	8. Medi-Cal Provider Number **used to bill the Medi-Cal Program for this beneficiary.** _ _ _ _ _ _ _ _ _ _ _ _
9. Telephone Number of Medi-Cal Physician (_ _ _) _ _ _ - _ _ _ _	10. Fax Number of Medi-Cal Physician (_ _ _) _ _ _ - _ _ _ _

MAIL COMPLETED FORM to: Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or FAX this form to:
(916) 364-0287

If you have questions regarding this form, please call HCO at 1-800-430-4263

MEDI-CAL MANAGED CARE NON-MEDICAL EXEMPTION

• See other side for the Non-Medical Exemption Form •

Indian Health Program Exemption:

Dear Medi-Cal Beneficiary: If you or a family member is receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you or a family member is a Native American, Alaskan Native or qualified non-Indian and you want to receive medical services through an Indian Health Service (IHS) facility, you may request to be excused from Medi-Cal Managed Care health plan enrollment in order to receive services through an Indian Health Service facility.

To be excused from plan enrollment you must have an Indian Health Services facility representative complete this form, certifying that you are or will be receiving services from an Indian Health Service facility. The facility representative must submit this completed form to the HCO program.

Medi-Cal Waiver Program Exemption:

Dear Medi-Cal Beneficiary: If you are enrolled in a Medi-Cal waiver program which allows you to receive skilled nursing services at home or are enrolled in any of the waiver programs listed below, you may NOT have to join a plan.

If you are enrolled in a Medi-Cal waiver program and wish to continue receiving medical services from your doctor, clinic or other primary care provider, you must have your doctor complete this form. If approved, you will NOT have to join a Medi-Cal Managed Care health plan for up to 12 months. At the end of 12 months, if an extension is required, your doctor must submit a new form. Your approval for medical exemption will allow you to continue to receive medical services through fee-for-service Medi-Cal by using your white Medi-Cal card.

Medi-Cal Waiver Programs:

- AIDS Waiver Program
- Model Waiver Program
- In-Home Medical Care (IHMC) Waiver Program
- Skilled Nursing Facility (SNF) Waiver Program

EXCEPCIÓN POR RAZONES NO MÉDICAS PARA ATENCIÓN MÉDICA ADMINISTRADA DE MEDI-CAL

• Vea el reverso de este formulario para información sobre la Excepción por Razones Médicas •

Excepción para el Programa Indian Health Program:

Estimado beneficiario de Medi-Cal: Si usted o un miembro de su familia está recibiendo beneficios de Medi-Cal, es posible que deba inscribirse en un Plan de Salud Administrado de Medi-Cal. Sin embargo, si usted o un miembro de su familia es de origen Indígena Americano, Nativo de Alaska o reúne los requisitos para personas de origen no indígena y desea recibir servicios médicos a través de un centro de Indian Health Service (IHS), puede solicitar que esté excluido de inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal para recibir los servicios a través del centro de Indian Health Service.

Para que esté excluido de inscribirse en el plan, debe solicitarle a un representante del centro de Indian Health Services que llene este formulario, en el que certifica que usted recibe o recibirá servicios a través de un centro de Indian Health Service. El representante del centro debe enviar este formulario completo al programa HCO.

Excepción para los programas de renuncia a Medi-Cal:

Estimado beneficiario de Medi-Cal: Si está inscrito en un programa de renuncia a Medi-Cal que le permite recibir servicios de atención médica especializada en el hogar o en cualquiera de los programas de renuncia que figuran a continuación, tal vez NO tenga que inscribirse en un plan.

Si está inscrito en un programa de renuncia a Medi-Cal y desea continuar recibiendo servicios médicos a través de su médico, clínica, u otro proveedor de atención médica primaria, debe solicitarle a su médico que llene este formulario. Si se aprueba su solicitud, NO tendrá que inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal durante un período de hasta 12 meses. Al cumplirse los 12 meses, si se requiere una extensión, su médico deberá presentar un nuevo formulario. Su aprobación para una excepción por razones médicas le permitirá continuar recibiendo servicios médicos mediante el sistema de pago por servicio de Medi-Cal (fee-for-service), utilizando su tarjeta blanca de Medi-Cal.

Programas de renuncia a Medi-Cal:

- Programa de renuncia para SIDA (AIDS Waiver Program)
- Programa de renuncia modelo (Model Waiver Program)
- Programa de renuncia para atención médica en el hogar (In-Home Medical Care (IHMC) Waiver Program)
- Programa de renuncia para atención médica especializada (Skilled Nursing Facility (SNF) Waiver Program)