Medi-Cal Choice Form

Please fill in both sides.

Department of Health Care Services

For free help filling out this form, call 1-800-430-4263.

1. Please print. Use a blue or black pen.
2. Fill in the ○ to show your choice. Fill it in completely: ●
3. Fill in **all information** for **each person** in your household who gets Medi-Cal.
4. If you have more than 3 family members, call **1-800-430-4263** to ask for another form.

Head of Household

Sex: ○ Male ○ Female

_____ _____ (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

⬆ First Name ⬆ Last Name ⬆ Area Code ⬆ Telephone or Cell Phone Number

_____ _____ ___ ___ ___ ___ ___

⬆ Home Address: house number, street name, apartment number ⬆ City ⬆ Zip Code

1st Applicant

_____ _____ Sex: ○ Male ○ Female

⬆ First Name ⬆ Last Name

___ ___ ___ – ___ ___ – ___ ___ ___ ___ If pregnant, due date: ___ ___ – ___ ___ – ___ ___

⬆ Social Security Number ⬆ Month ⬆ Day ⬆ Year

I want to be in: ○ Blue Cross* ○ Care 1st* ○ HealthNet* ○ Kaiser* ○ Western Health Advantage* ○ Regular Medi-Cal (No clinic code needed)

*Doctor or clinic code for your new health plan choice above: _____

(To find the code number, look in the Provider Directory for the plan you choose. It is usually written under the name of your provider. It can also be called a "PCP#" or "Provider Identification Number.")

2nd Applicant

_____ _____ Sex: ○ Male ○ Female

⬆ First Name ⬆ Last Name

___ ___ ___ – ___ ___ – ___ ___ ___ ___ If pregnant, due date: ___ ___ – ___ ___ – ___ ___

⬆ Social Security Number ⬆ Month ⬆ Day ⬆ Year

I want to be in: ○ Blue Cross* ○ Care 1st* ○ HealthNet* ○ Kaiser* ○ Western Health Advantage* ○ Regular Medi-Cal (No clinic code needed)

*Doctor or clinic code for your new health plan choice above: _____

(To find the code number, look in the Provider Directory for the plan you choose. It is usually written under the name of your provider. It can also be called a "PCP#" or "Provider Identification Number.")

3rd Applicant

_____ _____ Sex: ○ Male ○ Female

⬆ First Name ⬆ Last Name

___ ___ ___ – ___ ___ – ___ ___ ___ ___ If pregnant, due date: ___ ___ – ___ ___ – ___ ___

⬆ Social Security Number ⬆ Month ⬆ Day ⬆ Year

I want to be in: ○ Blue Cross* ○ Care 1st* ○ HealthNet* ○ Kaiser* ○ Western Health Advantage* ○ Regular Medi-Cal (No clinic code needed)

*Doctor or clinic code for your new health plan choice above: _____

(To find the code number, look in the Provider Directory for the plan you choose. It is usually written under the name of your provider. It can also be called a "PCP#" or "Provider Identification Number.")

If anyone in your family is changing Medi-Cal Health Plans, please fill in all of the reasons why:

○ Could not choose desired doctor. ○ Plan did not meet needs. ○ Doctor did not meet needs. ○ Doctor was too far away.

○ Did not choose this plan. ○ Moving out of the county. ○ Other: _____

Please fill in other side.

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Please fill in both sides.

Department of Health Care Services

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STATEMENT OF UNDERSTANDING: I understand that by filling out and signing this form, I am choosing how to get my Medi-Cal health care.

I understand that the Department of Health Care Services will keep the information on this form. They will only use it to enroll or disenroll me from a Medi-Cal Health Plan. Other government agencies that serve Medi-Cal members can also see this information. I can look at the files that Medi-Cal keeps on me, unless they are being used in an investigation or lawsuit. (To see your Medi-Cal file, contact the Department of Health Care Services at the address below.)

If You Chose a Medi-Cal Health Plan: I have read the description of the plan I want to join.

If You Join Kaiser: I understand that Kaiser requires binding arbitration. This means that I give up my right to a jury or court trial for medical malpractice and other disagreements about benefits and services. Instead, I would help choose independent professionals who would make a decision about the problem. I can still ask for a Medi-Cal State Hearing.

Please Sign Below:

Head of Household _____ Date: ___ ___ – ___ ___ – ___ ___
⬆ Signature ⬆ Month ⬆ Day ⬆ Year

1st Applicant
if under 18 years, parent or guardian: _____ Date: ___ ___ – ___ ___ – ___ ___
⬆ Signature ⬆ Month ⬆ Day ⬆ Year

2nd Applicant
if under 18 years, parent or guardian: _____ Date: ___ ___ – ___ ___ – ___ ___
⬆ Signature ⬆ Month ⬆ Day ⬆ Year

3rd Applicant
if under 18 years, parent or guardian: _____ Date: ___ ___ – ___ ___ – ___ ___
⬆ Signature ⬆ Month ⬆ Day ⬆ Year

Mail To:

California Dept. of Health Services
Health Care Options
Box 989009
West Sacramento, CA 95798-9850

Please fill in other side.