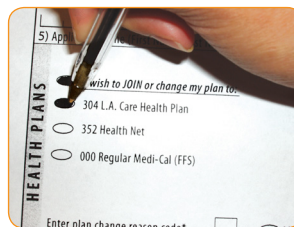


# Staying with your doctor is easy!

You will find the Medi-Cal Choice Enrollment Form in your packet from the state. If you have lost it, you can go to [www.healthcareoptions.dhcs.ca.gov](http://www.healthcareoptions.dhcs.ca.gov) to download a new one. Use a blue or black ink pen to complete the form. Fill in as much information as you can. If you need help filling out the form, you can call Health Care Options, toll free at 1-800-430-4263.

## To make sure you stay with your doctor, follow these easy steps:

**STEP 1** Enroll with L.A. Care, fill in the bubble next to “L.A. Care Health Plan” under “Health Plans.”



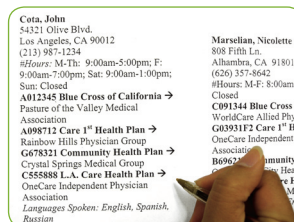
HEALTH PLANS

304 L.A. Care Health Plan

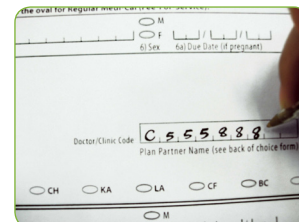
352 Health Net

000 Regular Medi-Cal (FFS)

**STEP 2** Next, write the code number for your doctor that is listed on the attached sheet.



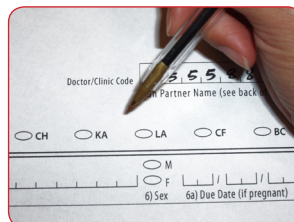
Ceta, John 54321 Olive Blvd. Los Angeles, CA 90012 (213) 987-1234 #Hours: M-Th: 9:00am-5:00pm; F: 9:00am-7:00pm; Sat: 9:00am-1:00pm; Sun: Closed A012345 Blue Cross of California → Pasture of the Valley Medical Association A998712 Care 1 <sup>st</sup> Health Plan → Rainbow Hills Physician Group G278321 Community Health Plan → Crystal Springs Medical Group C555888 L.A. Care Health Plan → OneCare Independent Physician Association Languages Spoken: English, Spanish, Russian	Marselian, Nicolette 808 Fifth Ln. Alhambra, CA 91801 (626) 357-8642 #Hours: M-F: 8:00am-6: Closed C991344 Blue Cross of WorldCare Allied Phys G0393182 Care 1 <sup>st</sup> He OneCare Independent P Association B09621 Community H OneCare Health OneCare He Med 987
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Doctor/Clinic Code C 5 5 5 8 8 8

Plan Partner Name (see back of choice form)

**STEP 3** Then, fill in the bubble “LA” for L.A. Care Health Plan.



Doctor/Clinic Code C 5 5 5 8 8 8

Plan Partner Name (see back of choice form)

CH  KA  LA  CF  BC

**STEP 4** Now fill out the rest of the form as much as you can. Be sure to sign your name and enter the date. Put the form in the envelope provided, drop it in the mail and you're done!

## What happens next?

Soon, you should receive a health plan ID card from L.A. Care. You will also get information on how to use your Medi-Cal benefits.

## Be sure to mail your completed Enrollment Form to:

California Department of Health Care Services  
Health Care Options  
Box 989009  
Sacramento, CA 95798-9850

To make sure you remain with Rancho, follow these easy steps:



### MEDI-CAL CHOICE FORM

Use this form to join or change health plans. If you need help filling out this form, call 1-800-430-4263.

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

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE OVALS TO INDICATE YOUR CHOICE.

M  
 F

1) Head of Household Name (First Name, Last Name) JOHN SMITH      2) Sex      3) Telephone Number 562-123-4567

4) Home Address (House Number, Street, Apartment Number, City, and Zip Code) 1111 MAIN ST, DOWNEY 90242

Please choose a Health Plan from the list for each member listed. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

M  
 F

5) Applicant's Name (First Name, Last Name) JOHN SMITH      6) Sex      6a) Due Date (if pregnant)      6b) Social Security Number 123-45-6789

I wish to JOIN or change my plan to:  
 304 L.A. Care Health Plan  
 352 Health Net Comm Solutions  
 000 Regular Medi-Cal (FFS)

Doctor/Clinic Code PE959MH

Plan Partner Name (see back of choice form)  
 CH  MO  LA  BC  KA  HN  CF

Enter plan change reason code\*



**Step 1**  
Enroll with LA Care, fill in the bubble next to "LA Care Health Plan" under "Health Plans."



**Step 2**  
Next, write the code number for your doctor that is listed on the attached sheet.



M  
 F

5) Applicant's Name (First Name, Last Name)      6) Sex      6a) Due Date (if pregnant)      6b) Social Security Number

I wish to JOIN or change my plan to:  
 304 L.A. Care Health Plan  
 352 Health Net Comm Solutions  
 000 Regular Medi-Cal (FFS)

Doctor/Clinic Code

Plan Partner Name (see back of choice form)  
 CH  MO  LA  BC  KA  HN  CF

Enter plan change reason code\*

**Step 3**  
Then, fill in the bubble "LA" for LA Care Health Plan.

M  
 F

5) Applicant's Name (First Name, Last Name)      6) Sex      6a) Due Date (if pregnant)      6b) Social Security Number

I wish to JOIN or change my plan to:  
 304 L.A. Care Health Plan  
 352 Health Net Comm Solutions  
 000 Regular Medi-Cal (FFS)

Doctor/Clinic Code

Plan Partner Name (see back of choice form)  
 CH  MO  LA  BC  KA  HN  CF

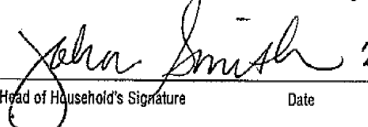
Enter plan change reason code\*

**\*PLAN CHANGE REASON CODES:**

Code 1: I could not choose the doctor or dentist I wanted	Code 4: Too far to go	Code 7: Indian Health Program Exemption.
Code 2: The health/dental plan did not meet my needs	Code 5: I did not choose this plan	Code 8: Medical/Dental Exemption
Code 3: My doctor/dentist did not meet my needs	Code 6: Moving out of the county	Code 9: 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 medical 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 Health plan, I/we must complete this form.

      2-21-11

Head of Household's Signature      Date      Other Adult's Signature      Date      Other Adult's Signature      Date



**Step 4**  
Now, sign your name and enter the date.



# MEDI-CAL CHOICE FORM

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

PLEASE PRINT CLEARLY USING BLUE OR BLACK INK ONLY. COMPLETELY FILL IN THE OVALS ● TO INDICATE YOUR CHOICE. SEE BACK FOR EXAMPLE

1) Head of Household Name (First Name, Last Name) \_\_\_\_\_

2) Sex  M  F

3) Telephone Number \_\_\_\_\_

4) Home Address (House Number, Street, Apartment Number, City, and Zip Code) \_\_\_\_\_

Please choose a Health Plan from the list for each member listed. The Doctor/Clinic Codes can be found in the Health Plan Provider Directory.

5) Applicant's Name (First Name, Last Name) \_\_\_\_\_

6) Sex  M  F

6a) Due Date (if pregnant) \_\_\_\_\_

6b) Social Security Number \_\_\_\_\_

**HEALTH PLANS**

I wish to JOIN or change my plan to:

304 L.A. Care Health Plan

352 Health Net Comm Solutions

000 Regular Medi-Cal (FFS)

Doctor/Clinic Code \_\_\_\_\_

Plan Partner Name (see back of choice form) \_\_\_\_\_

Enter plan change reason code\*   CH  MO  LA  BC  KA  HN  CF

5) Applicant's Name (First Name, Last Name) \_\_\_\_\_

6) Sex  M  F

6a) Due Date (if pregnant) \_\_\_\_\_

6b) Social Security Number \_\_\_\_\_

**HEALTH PLANS**

I wish to JOIN or change my plan to:

304 L.A. Care Health Plan

352 Health Net Comm Solutions

000 Regular Medi-Cal (FFS)

Doctor/Clinic Code \_\_\_\_\_

Plan Partner Name (see back of choice form) \_\_\_\_\_

Enter plan change reason code\*   CH  MO  LA  BC  KA  HN  CF

5) Applicant's Name (First Name, Last Name) \_\_\_\_\_

6) Sex  M  F

6a) Due Date (if pregnant) \_\_\_\_\_

6b) Social Security Number \_\_\_\_\_

**HEALTH PLANS**

I wish to JOIN or change my plan to:

304 L.A. Care Health Plan

352 Health Net Comm Solutions

000 Regular Medi-Cal (FFS)

Doctor/Clinic Code \_\_\_\_\_

Plan Partner Name (see back of choice form) \_\_\_\_\_

Enter plan change reason code\*   CH  MO  LA  BC  KA  HN  CF

INTERNAL USE ONLY

**\*PLAN CHANGE REASON CODES:**

<b>Code 1:</b> I could not choose the doctor or dentist I wanted	<b>Code 4:</b> Too far to go	<b>Code 7:</b> Indian Health Program Exemption
<b>Code 2:</b> The health/dental plan did not meet my needs	<b>Code 5:</b> I did not choose this plan	<b>Code 8:</b> Medical/Dental Exemption
<b>Code 3:</b> My doctor/dentist did not meet my needs	<b>Code 6:</b> Moving out of the county	<b>Code 9:</b> 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.

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Head of Household's Signature \_\_\_\_\_ Date \_\_\_\_\_ Other Adult's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Highly Confidential

