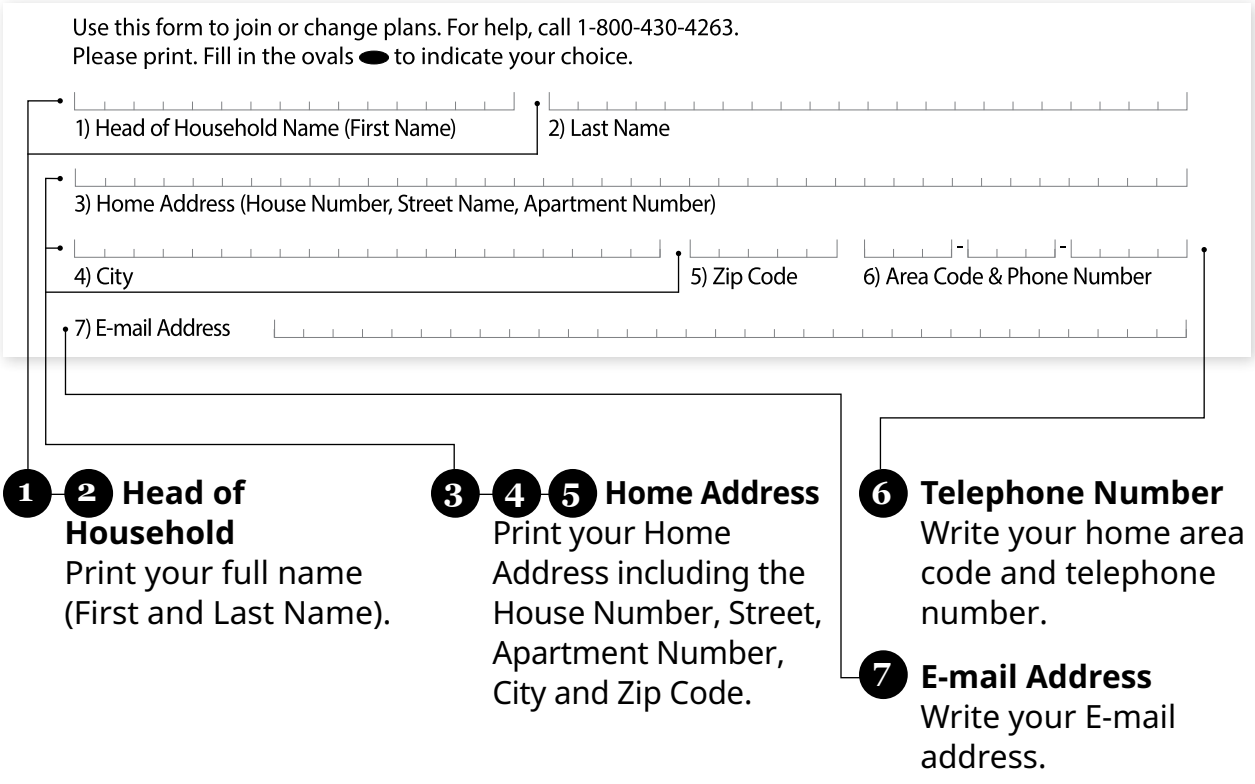
How to Fill Out the Medi-Cal Choice Form

Use the **MEDI-CAL CHOICE FORM(S)** in this packet. Fill out one form for each family member. You can get more forms by calling Health Care Options at 1-800-430-4263.

Please print clearly, using blue or black ink only. Write in block letters, and completely fill in all areas to indicate your choice. **See the backside of the choice form for an example.**

Lines 1 through 7

This section is to be completed by the Medi-Cal head of household.



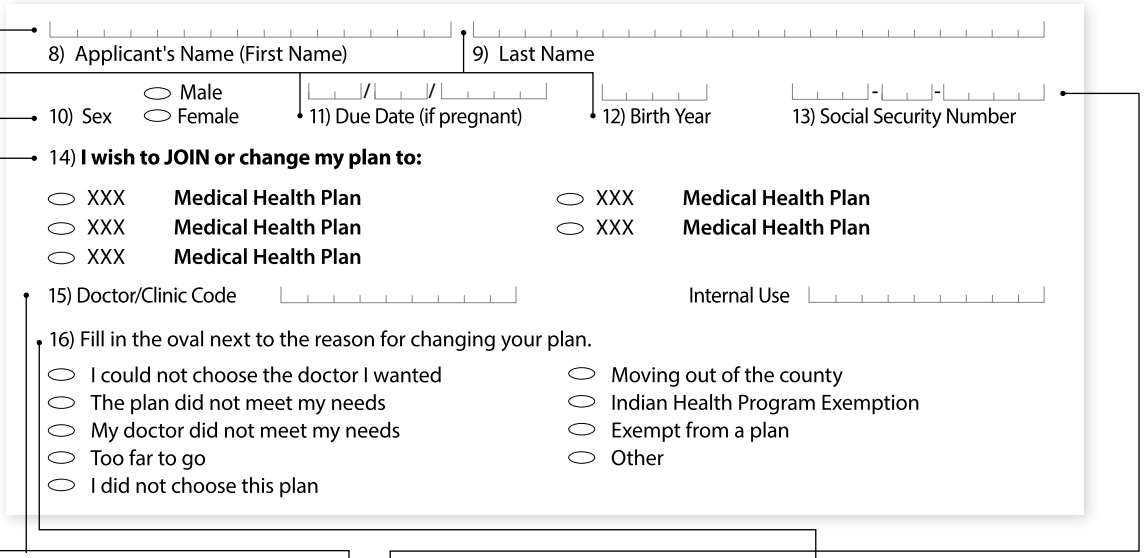
CHOOSING A HEALTH PLAN

Before going on with the form, choose a health plan for each family member. You can choose different plans for each family member. You can also choose different doctors in the same health plan for each family member. After you have made your health plan choice, you can complete the Medi-Cal Choice Form.

Join or Change a Health Plan

Lines 8 through 16

Please complete the Health Plan section for all members who must join or want to change a health plan. Parts of this section may already be filled in for you.



8 **9** **Applicant**
Print the full name (First and Last name) of the individual member of your family who must join or wants to change a health plan.

10 **Sex**
Fill in the sex.

11 **Due Date**
The due date is the day the baby is expected to be born (month/day/year). For example, December 2, 2003 would be entered as 12/2/2003.

12 **Birth Year**
List the year the applicant was born.

13 **Social Security Number**
Do nothing if there is a bar code in this space. Otherwise, enter **the applicant's** Social Security Number.

14 **Join or Change a Health Plan**
Fill in the oval next to the health plan you wish to join.

15 **Doctor/Clinic Code**
Write the code number for the doctor or clinic. This information can be found in the Plan Provider Directory. If there is no number, leave this blank.

The code number may be listed in the Provider Directory as:

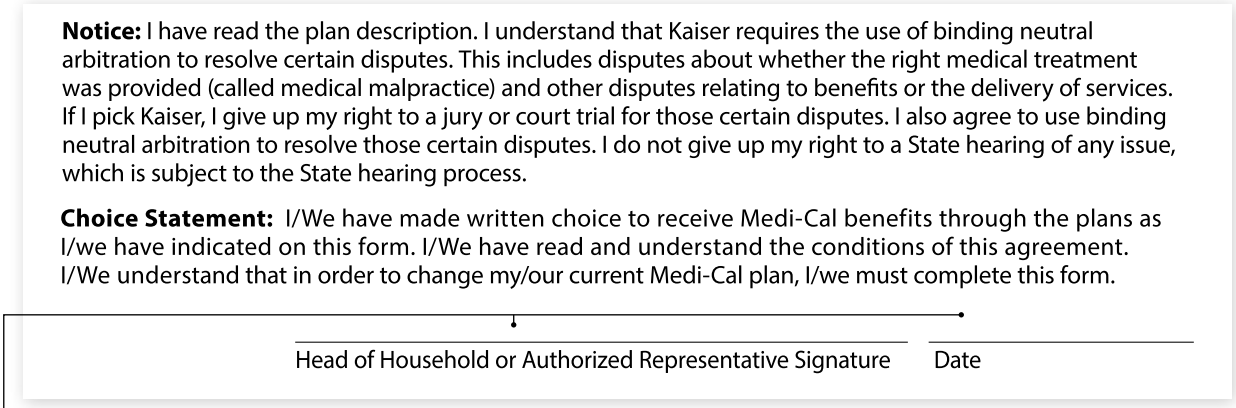
- Doctor's Code
- Clinic Code
- PCP #
- Identification Number (ID)
- Doctor I.D. Number
- PIN (Provider Identification Number)
- Provider 0000 (ex. Provider 3322)

16 **To Change a Plan**
Fill in the oval next to the reason why you are changing your plan. If your reason is not listed, fill in the oval next to "Other".

Completing and Mailing the Choice Form

Sign and Date

Make sure the form is signed by the applicant, or representative.



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.

Head of Household or Authorized Representative Signature _____ Date _____

Sign and Date

Print the full name (First and Last name) of the individual member of your family who must join or wants to change a health plan.

You're Done!

Use the envelope included in this packet to mail the form. It does not need a stamp. Keep the last copy of the form for your records.

If you have questions or need help filling out this form, call Health Care Options at 1-800-430-4263. There are also meetings you can attend to discuss health plan choices. See the Health Care Options Presentation Schedule in this packet.

DO NOT CALL YOUR ELIGIBILITY WORKER IF YOU HAVE QUESTIONS ABOUT YOUR MEDI-CAL CHOICE FORM. Your Eligibility Worker can only help you with questions about Medi-Cal benefits or eligibility.