Health Plan Choice Form

California Department of
Health Care Services
P.O. Box 989009
W. Sacramento, CA 95798-9850

CCIPB

If you do not want to automatically enroll in the Cal MediConnect plan we have chosen for you, use this form to choose a different option. For Free Help with this form, contact Health Care Options at 1-844-580-7272.

STEP 1: Tell us about yourself:

John Sample
First Name, Last Name

M- -XXXXXXXXX-H

1234 Sample Street Sample City
Address, City

9 9 9 9 9
Zip Code

Date of Birth

(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
(Area Code) Phone Number

Sex: ○ Male ○ Female

If pregnant, due date ___ ___ - ___ ___ - ___ ___
Month Day Year

STEP 2: Choose how you want your care:

If you do NOT make a choice, you will be automatically enrolled in a Cal MediConnect Plan we have chosen for you.

OPTION A

Combine my Medicare and Medi-Cal benefits in one plan.

Choose one of these Cal MediConnect Plans:

○ 810 IEHP DualChoice *
○ 811 Molina Dual Options

* To choose the plan that you have been assigned to, select the plan with the asterisk (*).

OR

OPTION B

Keep my Medicare the way it is now AND choose a Medi-Cal plan.

Choose one of these Medi-Cal Plans to get your Medi-Cal benefits:

○ 305 Inland Empire Health Plan
Plan Partners
☐ KA KP Cal, LLC

○ 355 Molina Healthcare Partner
Plan Partners
☐ HN Health Net Comm Solutions

Program of the All-Inclusive Care for the Elderly (PACE):
You may qualify for PACE (see instructions). If you want to get your Medicare and Medi-Cal benefits combined in a PACE plan, fill out this option in addition to Option A or B.

If you do not qualify, you will get your care through the Option A or Option B plan that you chose above in Step 2.

PACE Plan:

○ 061 InnovAge

STEP 3: Read the important information on the back before signing. I understand that by filling out and signing this form, I am choosing how to get my health care.

Beneficiary's signature Date OR Authorized Representative Signature *(if any)* Date

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Highly Confidential

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