Health Plan Choice Form Instructions

If you want to choose a different Cal MediConnect plan or choose a Medi-Cal plan, please fill out the Health Plan Choice Form in this Choice Book. Please read the important information on the back of the Health Plan Choice Form before signing and mailing the Choice Form.

❶ Personal Contact Information

- Do nothing if your name and other information are correctly filled in.
- If there are errors, please correct them on this form.
- If there are any blanks, fill them in.

❷ If Pregnant

Fill in the month, day, and year the baby is expected to be born (example 12-23-14).

❸ Pick a Cal MediConnect plan

If you want your Medicare and Medi-Cal Long Term Services and Supports (LTSS) to work together, fill in the circle (◯) to the left of the Cal MediConnect plan you want. To learn more about Cal MediConnect Plans, look in the Cal MediConnect Health Plan Guidebook on pages 8-10. For more help, use the information in this packet of materials or call Heath Care Options at 1-844-580-7272.

❹ Pick a doctor or clinic

If you want, fill out the doctor or clinic code for the Cal MediConnect doctor or clinic you choose. To find the doctor or clinic code, contact the health plan for their provider directory. This doctor or clinic code is next to or under the doctor or clinic name. The doctor or clinic code can also be called a PCP#, a PCP ID#, NPI, or #. All codes are 10 characters or less.

❺ Pick a Medi-Cal plan for your Medi-Cal Services

If you don't pick a Cal MediConnect plan, you must pick a Medi-Cal plan. Fill in the circle (◯) to the left of the Medi-Cal plan you want. If listed, and you want to pick a plan partner, fill in the plan partner square (☐) under the Medi-Cal plan you choose. To learn more about Medi-Cal Plans, look in the Cal MediConnect Health Plan Guidebook on pages 11 and 12. For more help, use the information in this packet of materials or call Health Care Options at 1-844-580-7272.

❻ Changing your health plan

If you are already in a plan but choosing a different plan, please help us understand the reason for this change. Look at the Reason Codes below and choose the Reason Code that best describes the reason for your health plan change. Fill out a Reason Code number you selected in the box ⌊ ⌋ in ❻. If you are not changing plans, leave ❻ blank.

- Reason Code 1 I could not choose the doctor I wanted
- Reason Code 2 The health plan did not meet my needs
- Reason Code 3 My doctor did not meet my needs
- Reason Code 4 Too far to go
- Reason Code 5 I did not choose this plan
- Reason Code 6 Moving out of the county
- Reason Code 9 Other

❼ Program of the All-Inclusive Care for the Elderly (PACE)
If you are age 55 or older and live in an applicable zip code, then PACE may be a choice for you. If PACE ❼ is listed on your Health Plan Choice Form and you pick a PACE plan, you must also pick a Cal MediConnect plan from ❸ **or** a Medi-Cal plan from ❺.

Sign and date your completed Health Plan Choice Form
Use the envelope in this Health Plan Choice Book to mail your completed Health Plan Choice Form. You do not need a stamp if you use the enclosed envelope.