Choice Form Instructions

For forms mailed after 9/1/2014

CalMediConnect
Your choice for complete care

www.CalDuals.org

Health Plan Choice Form

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

CCIPB

Use this form to join or change a health plan. For FREE help with this form, contact Health Care Options at 1-844-580-7272. Mail completed form to California Department of Health Care Services, Health Care Options, P.O. Box 989009, West Sacramento, CA 95798-9850. Please print clearly using blue or black ink.

STEP 1: Tell us about yourself:

JOHN SAMPLE
First Name, Last Name

M-0-999999999-IMC

1234 SAMPLE STREET LOS ANGELES
Address, City

9 0 0 1 3
Zip Code

Date of Birth

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

Sex: ○ Male ○ Female

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

STEP 2: Choose your health plan:

CHOICE A

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

Choose one of these Cal MediConnect plans:

- ○ 800 L.A. Care
- ○ 801 Health Net
- ○ 816 Molina Dual Options
- ○ 817 Blue Shield Promise
- ○ 818 Anthem

Doctor/Clinic Code: _____ (optional)

OR

CHOICE B

Keep my Medicare separate AND choose a Medi-Cal Managed Care plan.

Choose one of these Medi-Cal Managed Care plans to get your Medi-Cal benefits:

- ○ 304 L.A. Care Health Plan
  - Plan Partners
    - ☐ BC Anthem Blue Cross Partnrshp
    - ☐ BL Blue Shield Promise
    - ☐ KA KP Cal, LLC
    - ☐ LA L.A. Care Health Plan
- ○ 352 Health Net Comm Solutions
  - Plan Partners
    - ☐ HN Health Net Comm Solutions
    - ☐ MO Molina Healthcare Partner

Doctor/Clinic Code: _____ (optional)

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 Choice A or B**.

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

PACE Plan:
○ 052 AltaMed Senior BuenaCare

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.

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

CCIPB

Confidential

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1 Check that your name and other information are correct

2 Add date, or leave blank if you are not currently pregnant

3 **If you want to enroll in a Cal MediConnect Plan,** fill in the circle of the plan you want

4 If you want to keep **Original Medicare**, select a Medi-Cal health plan

5 **If you want PACE,** fill in the circle, but also pick a Cal MediConnect plan from **Option A** or a Medi-Cal plan from **Option B** (Choose one or the other, but not both) as your 2nd choice

6 Sign and date HERE

Los Angeles County's Choice Form is shown above. Health plans in your county may be different.