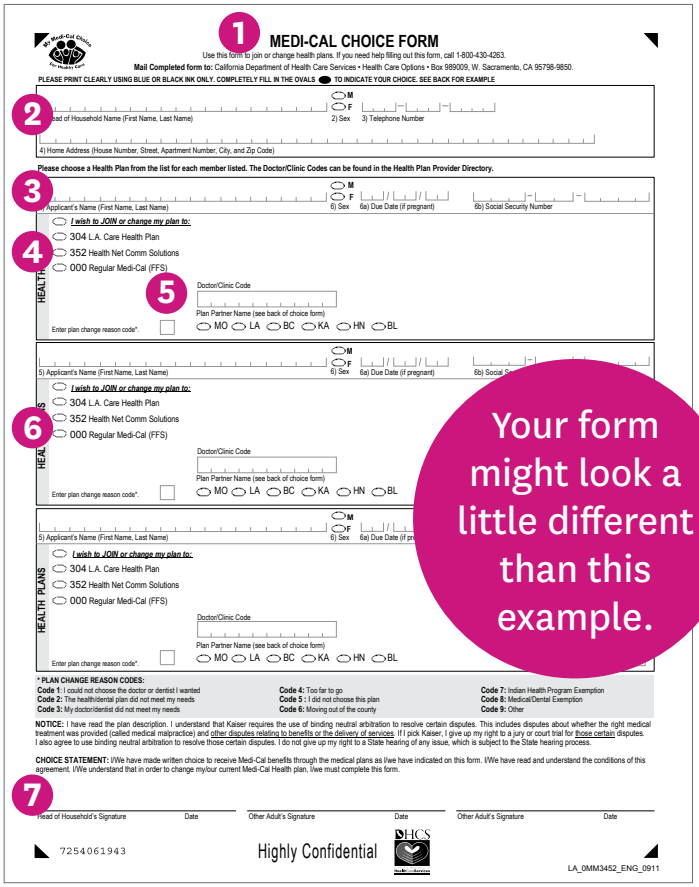
How to Enroll in a Health Net Medi-Cal Plan

Follow the steps below to enroll in a plan and choose your doctor. Please print clearly, and use blue or black ink.

1. Start with the Medi-Cal Choice Form. Use this form to enroll in your medical plan.
2. Complete the top part of the form (name, address, telephone number, etc.).
3. The next part of the form is about each person in your household who will be enrolling in the plan. Start with your information first.
4. Fill in the oval next to Health Net. Fill in the oval completely with black or blue ink.

   Do: ⬬ ⬬ **Don't:** ✓ ⊘

5. Next, add the Doctor/Clinic Code for your personal doctor.
   - Go to **www.healthnet.com** and click *Find a Provider,* then select *Medi-Cal*.
   - Click *View Details* in the search results to see more information about the doctor.
   - Find the 10-digit **National Provider Identifier** for your doctor. Write this number on the form where it says "Doctor/Clinic Code.'
6. Repeat steps 3–5 for every person you want to enroll.
7. Make sure each adult you're enrolling signs and dates the form.
8. Return the form in the enclosed envelope. You don't need stamps or postage.


1 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. SEE BACK FOR EXAMPLE
2 Head of Household Name (First Name, Last Name) M F 2) Sex 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.
3 5) Applicant's Name (First Name, Last Name) M F 6) Sex 6a) Due Date (if pregnant) 6b) Social Security Number
I wish to JOIN or change my plan to:
4 304 L.A. Care Health Plan
352 Health Net Comm Solutions
000 Regular Medi-Cal (FFS)
5 Doctor/Clinic Code
Plan Partner Name (see back of choice form)
Enter plan change reason code*. MO LA BC KA HN BL
5) Applicant's Name (First Name, Last Name) M F 6) Sex 6a) Due Date (if pregnant)
I wish to JOIN or change my plan to:
6 304 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*. MO LA BC KA HN BL
5) Applicant's Name (First Name, Last Name) M F 6) Sex
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*. MO LA BC KA HN BL
* PLAN CHANGE REASON CODES:
Code 1: I could not choose the doctor or dentist I wanted
Code 2: The health/dental plan did not meet my needs
Code 3: My doctor/dentist did not meet my needs
Code 4: Too far to go
Code 5 : I did not choose this plan
Code 6: Moving out of the county
Code 7: Indian Health Program Exemption
Code 8: Medical/Dental Exemption
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.
7 Head of Household's Signature Date Other Adult's Signature Date Other Adult's Signature Date
7254061943 Highly Confidential DHCS LA_0MM3452_ENG_0911

Your form might look a little different than this example.

If you need help, call us (toll-free):

1-800-327-0502 (TTY: 711)
Monday–Friday, 7:30 a.m. to 6 p.m.

You can also call Health Care Options (toll-free):

1-800-430-4263 (TTY: 711)
Monday–Friday, 8 a.m. to 5 p.m.

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