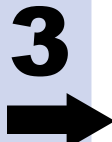
Choice Form Instructions

For forms mailed after 9/1/2014

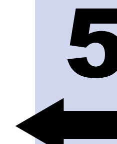
www.CalDuals.org

1 Check that your name and other information are correct

2 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

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.

Sample Form Contact Health Care Options for further information.

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:

- ○ 800 L.A. Care
- ○ 801 Health Net
- ○ 816 Molina Dual Options
- ○ 817 Care1st
- ○ 818 CareMore *

* 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:

- ○ 304 L.A. Care Health Plan
  - Plan Partners
  - ☐ CF Care1st Partner Plan, LLC
  - ☐ KA KP Cal, LLC
  - ☐ LA L.A. Care Health Plan
  - ☐ BC Anthem Blue Cross Partnrshp
- ○ 352 Health Net Comm Solutions
  - Plan Partners
  - ☐ HN Health Net Comm Solutions
  - ☐ MO Molina Healthcare Partner

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:
○ 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.

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

CCIPB

Highly Confidential

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