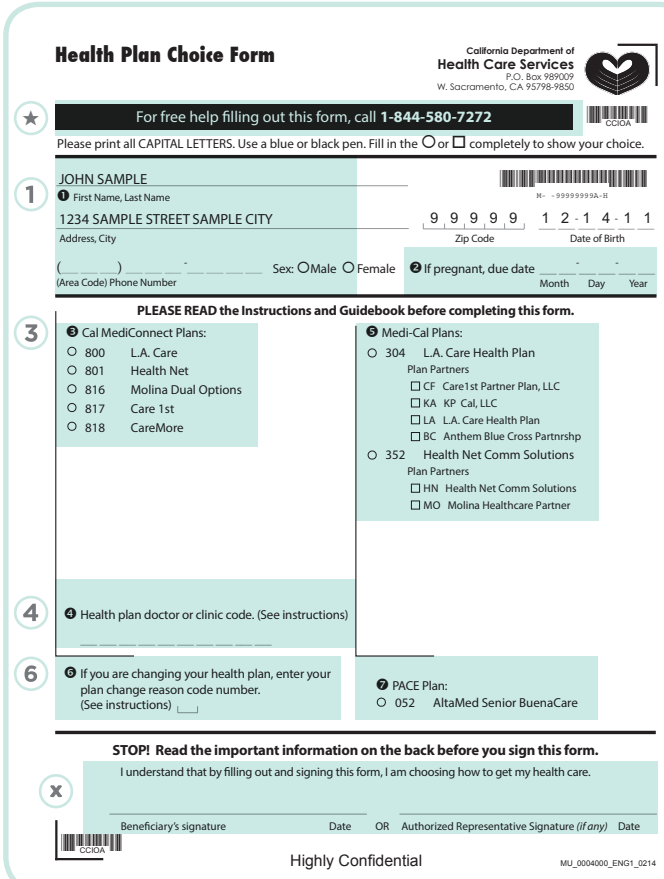
# COMPLETING YOUR HEALTH PLAN CHOICE FORM

## Opting Out of the Cal MediConnect Pilot

★ If you have questions about how to keep coverage for Cedars-Sinai and with Cedars-Sinai health providers, please call **844-CS-MEDIS** (844-276-3347). Representatives are available 24 hours a day, seven days a week.



**Health Plan Choice Form**

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

★ For free help filling out this form, call **1-844-580-7272**

CCIOA

Please print all CAPITAL LETTERS. Use a blue or black pen. Fill in the ○ or ☐ completely to show your choice.

1 JOHN SAMPLE
❶ First Name, Last Name

1234 SAMPLE STREET SAMPLE CITY
Address, City

99999 Zip Code

12-14-11 Date of Birth

( ) - Sex: ○ Male ○ Female
(Area Code) Phone Number

❷ If pregnant, due date - -
Month Day Year

**PLEASE READ the Instructions and Guidebook before completing this form.**

3 ❸ Cal MediConnect Plans:
- ○ 800 L.A. Care
- ○ 801 Health Net
- ○ 816 Molina Dual Options
- ○ 817 Care 1st
- ○ 818 CareMore

❺ Medi-Cal Plans:
- ○ 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

4 ❹ Health plan doctor or clinic code. (See instructions)

6 ❻ If you are changing your health plan, enter your plan change reason code number. (See instructions)

❼ PACE Plan:
- ○ 052 AltaMed Senior BuenaCare

**STOP! Read the important information on the back before you sign this form.**

x 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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x Sign and date the form. Return the form in the envelope that was provided.

7 You only need to complete No. 7 if you qualify for PACE. (Age 55 and over, need special care and assistance, would like to remain in your home, and live in the program service area)

1 This information will be completed for you, but you should review it to make sure that everything is accurate. If anything is not correct, make corrections. If anything is blank, fill in the space with the correct information.

2 If you are pregnant, write in the month, day and year that your baby is expected to be born.

3 If you do not want to participate in Cal MediConnect, you do not need to complete No. 3 or

4 No. 4. Leave these blank and fill out No. 5.

5 If you want to opt out of Cal MediConnect, you must complete No. 5 by selecting a Medi-Cal plan (fill in one of the circles) and a Plan Partner (fill in one of the squares under the circle you filled in).

6 If this is the first time you are making a selection, you can leave No. 6 blank.

If you are enrolled in a plan and you are using the form to switch plans, then you should use No. 6 to indicate why you are changing plans.

The reason codes are as follows:

- 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

CEDARS-SINAI®