



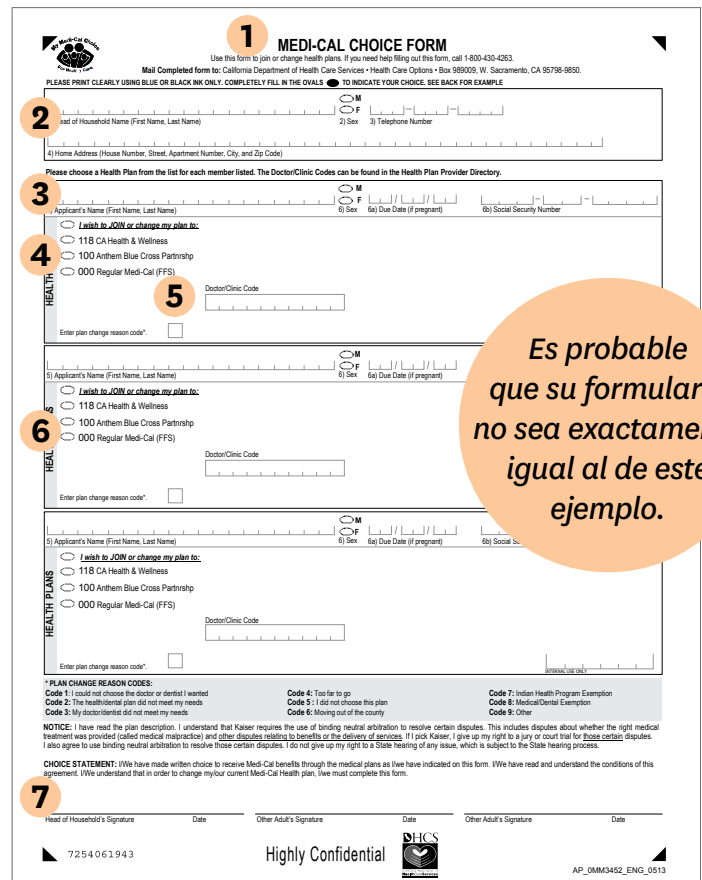


Cómo Inscribirse en un Plan Medi-Cal de California Health & Wellness

Siga los pasos que se indican a continuación para inscribirse en un plan y elegir su médico. Complete con letra de imprenta legible y use tinta azul o negra.

1. Comience por el formulario de elección de Medi-Cal. Use este formulario para inscribirse en su plan médico.
2. Complete la parte superior del formulario (nombre, dirección, número de teléfono, etc.).
3. La siguiente parte del formulario es sobre cada una de las personas de su hogar que se inscribirán en el plan. Primero, complete con la información sobre usted.
4. Rellene el óvalo que se encuentra junto a “California Health & Wellness”. Rellénelo completamente con tinta azul o negra.

Correcto:   **Incorrecto:**  
5. Luego, agregue el código del médico o de la clínica correspondiente a su médico personal.
 - Ingrese en www.cahealthwellness.com y haga clic en *Find a Provider* (Buscar un proveedor).
 - Haga clic en *View Details* (Ver detalles) en los resultados de la búsqueda para encontrar más información sobre el médico.
 - Busque el identificador de proveedor nacional de 10 dígitos correspondiente a su médico. Escriba este número en el formulario, donde dice “Doctor/Clinic Code” (Código del médico o de la clínica).
6. Repita los pasos 3 a 5 para cada persona que quiera inscribir.
7. Asegúrese de que cada adulto que inscriba firme y feche el formulario.
8. Envíe el formulario en el sobre adjunto. No es necesario poner sellos ni estampillas.



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 589009, 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) Sex Telephone Number

3 Home Address (House Number, Street, Apartment Number, City, and Zip Code)

4 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.

5 Applicant's Name (First Name, Last Name) Sex (a) Due Date (if pregnant) (b) Social Security Number

HEALTH I wish to JOIN or change my plan to:
 118 CA Health & Wellness
 100 Anthem Blue Cross Partnership
 000 Regular Medi-Cal (FFS)
 Doctor/Clinic Code
 Enter plan change reason code*

6 Applicant's Name (First Name, Last Name) Sex (a) Due Date (if pregnant) (b) Social Security Number

HEALTH I wish to JOIN or change my plan to:
 118 CA Health & Wellness
 100 Anthem Blue Cross Partnership
 000 Regular Medi-Cal (FFS)
 Doctor/Clinic Code
 Enter plan change reason code*

HEALTH PLANS I wish to JOIN or change my plan to:
 118 CA Health & Wellness
 100 Anthem Blue Cross Partnership
 000 Regular Medi-Cal (FFS)
 Doctor/Clinic Code
 Enter plan change reason code*

7 PLAN CHANGE REASON CODES:
 Code 1: I could not choose the doctor or dentist I wanted
 Code 2: The health/benefit plan did not meet my needs
 Code 3: My doctor/clinician 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 medical 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: 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.

Head of Household's Signature Date Other Adult's Signature Date Other Adult's Signature Date

7254061943 Highly Confidential DHCS

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Es probable que su formulario no sea exactamente igual al de este ejemplo.

Si necesita ayuda, llámenos a nuestro número gratuito:
1-800-685-7344 (TTY: 711)
 de lunes a viernes, de 7:30 a.m a 6:00 p.m.

Además, puede llamar al número gratuito de Opciones de Atención de Salud:
1-800-430-4263 (TTY: 711)
 de lunes a viernes, de 8:00 a.m a 5:00 p.m.

