

# How to select your health plan and doctor/clinic



**SAN FRANCISCO HEALTH PLAN™**

Here for you



## 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

1) Head of Household Name (First Name, Last Name) \_\_\_\_\_

2) Sex  M  F \_\_\_\_\_

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.

5) Applicant's Name (First Name, Last Name) \_\_\_\_\_

6) Sex  M  F \_\_\_\_\_

6a) Due Date \_\_\_\_\_

I wish to JOIN or change my plan to:

307 San Francisco Health Plan

343 Anthem Blue Cross Partnrshp

Doctor/Clinic Code

1 2 3 4 5

Plan Partner Name (see back of choice form) \_\_\_\_\_

KA

**1. If you want to choose San Francisco Health Plan, fill in bubble 307.**

**2. To choose your doctor or clinic, you must write the health plan's code number for the doctor or clinic**  
If you choose San Francisco Health Plan, the code number for your current doctor is:

7) Applicant's Name (First Name, Last Name) \_\_\_\_\_

8) Sex  M  F \_\_\_\_\_

8a) Due Date \_\_\_\_\_

8b) Social Security Number \_\_\_\_\_

I wish to JOIN or change my plan to:

307 San Francisco Health Plan

343 Anthem Blue Cross Partnrshp

000 Regular Medi-Cal (FFS)

Doctor/Clinic Code \_\_\_\_\_

Plan Partner Name (see back of choice form) \_\_\_\_\_

KA

9) Applicant's Name (First Name, Last Name) \_\_\_\_\_

10) Sex  M  F \_\_\_\_\_

10a) Due Date (if pregnant) \_\_\_\_\_

10b) Social Security Number \_\_\_\_\_

I wish to JOIN or change my plan to:

307 San Francisco Health Plan

343 Anthem Blue Cross Partnrshp

Doctor/Clinic Code \_\_\_\_\_

Plan Partner Name (see back of choice form) \_\_\_\_\_

KA

**\*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.

- **Providers:** Find your San Francisco Health Plan Code at [www.sfhp.org/providers](http://www.sfhp.org/providers) or call **(888) 626-6563**.
- To download a Medi-Cal Choice Form go to: [www.healthcareoptions.dhcs.ca.gov/HCOOSP/Enrollment/content/en/forms/SF\\_0MM3452.pdf](http://www.healthcareoptions.dhcs.ca.gov/HCOOSP/Enrollment/content/en/forms/SF_0MM3452.pdf)