

# Medi-Cal Choice Enrollment Form Completion Guide

LOS ANGELES COUNTY



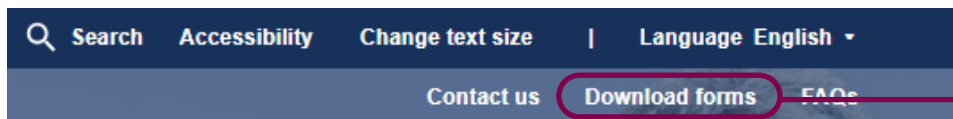


## What This Guide Helps You Do

- Support members in completing all required sections of the Medi-Cal Choice Enrollment form accurately, including indicating their health plan selection.
- Prevent common errors that lead to incomplete or rejected enrollment forms.
- Improve submission quality to support timely processing and coverage activation.

# Medi-Cal Choice Enrollment Form Access

Website: [www.healthcareoptions.dhcs.ca.gov](http://www.healthcareoptions.dhcs.ca.gov)



## Step 1

Click *Download forms*.

Choose a county from the drop down list to see materials for that county.

Choose your county:

A screenshot of a form for selecting a county. It has a white background. At the top, it says 'Choose your county:'. Below this is a dropdown menu with 'Los Angeles' selected and a small downward arrow. To the right of the dropdown is a dark blue button with the word 'Go' in white. Both the dropdown menu and the 'Go' button are circled in red.

## Step 2

Select *Los Angeles* and click *Go*.

## Choice enrollment forms

- [Medi-Cal Managed Care Choice Enrollment Form – Medical](#)

## Step 3

- Click *Medi-Cal Managed Care Choice Enrollment Form – Medical*.
- Download and print the PDF.

## Dental coverage

In Los Angeles County, Medi-Cal beneficiaries eligible for dental benefits also can choose Health Net\* Dental coverage.

Access the Medi-Cal Dental Choice Form at

[https://www.healthcareoptions.dhcs.ca.gov/content/dam/digital/united-states/california/ca-hco/download-forms/dental/en/10-20-2025/LA\\_OVD4103\\_ENG\\_0124.pdf](https://www.healthcareoptions.dhcs.ca.gov/content/dam/digital/united-states/california/ca-hco/download-forms/dental/en/10-20-2025/LA_OVD4103_ENG_0124.pdf).



## Need Help?

Contact Health Care Options Member Services

- Phone: 800-430-4263
- TTY: 800-430-7077

You can also call Health Net Enrollment Services – 800-327-0502

# Step 1–5: Member Information and Health Plan Selection

**Medi-Cal** Mail form back to: California Department of Health Care Services, P.O. Box 989009 • W. Sacramento, CA 95798-9850

**Medi-Cal Choice Form**  
Highly Confidential

Use this form to join or change plans. For help, call 1-800-430-4263.  
Please print. Fill in the ovals  to indicate your choice.

1) Head of Household Name (First Name) 2) Last Name

3) Home Address (House Number, Street Name, Apartment Number)

4) City 5) Zip Code 6) Area Code & Phone Number

7) E-mail Address

**Choose a plan and a plan partner from the list below. See the provider directory for Doctor/Clinic Codes.**

8) Applicant's Name (First Name) 9) Last Name

10) Sex  Male  Female 11) Due Date (If Pregnant) 12) Birth Year 13) Social Security Number

14) I wish to **JOIN** or change my plan to: (please select reason for change on the back of the form)

<input type="radio"/> 352 Health Net Comm Solutions	<input type="radio"/> 304 L.A. Care Health Plan
<input type="radio"/> HN Health Net Comm Solutions	<input type="radio"/> BC Anthem Blue Cross Partnrrshp
<input type="radio"/> MO Molina Healthcare Partner	<input type="radio"/> BL Blue Shield Promise
<input type="radio"/> 000 Regular Medi-Cal FFS	<input type="radio"/> LA L.A. Care Health Plan

**EXAMPLE ONLY – Available plans may vary**

15) Doctor/Clinic Code Internal Use

16) **Kaiser Permanente Health Plan:** You may qualify for Kaiser Permanente (see instructions). If you want to enroll in Kaiser Permanente, fill out this option in **addition to section 14**. If you do not qualify for Kaiser Permanente, you will get your care through the plan selected in Section 14.

368 Kaiser Permanente

17) **Program of All-Inclusive Care for the Elderly (PACE):** You may qualify for PACE. PACE plans have age, zip code, and backup plan requirements. If you want to enroll in a PACE plan, please call the Medi-Cal Health Care Options call center at 1-800-430-4263 (TTY 1-800-430-7077) so that we can check your eligibility and assist you through the process.

**EXAMPLE ONLY – Available plans may vary**

**Choice Statement:** I/We have made written choice to receive Medi-Cal benefits through the plans as I/we have indicated on this form. I/We have read and understand the conditions of this agreement on **both sides**. I/We understand that in order to change my/our current Medi-Cal plan, I/we must complete this form.

Head of Household or Authorized Representative Signature Date

LA\_OVMFOPS\_ENG\_1225

## Step 1

Enter Head of Household Name and Address.

## Step 2

Add Phone Number and contact information.

## Step 3

Provide the Applicant's Name, Sex, Birth Year and Social Security Number.

## Step 4

Remember to fill in the bubble.

## Step 5

Sign and date the form.

# Step 6–7: Provider Selection and Information

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**Medi-Cal Choice Form**  
Highly Confidential

Use this form to join or change plans. For help, call 1-800-430-4263.  
Please print. Fill in the ovals  to indicate your choice.

1) Head of Household Name (First Name) 2) Last Name

3) Home Address (House Number, Street Name, Apartment Number)

4) City 5) Zip Code 6) Area Code & Phone Number

7) E-mail Address

**Choose a plan and a plan partner from the list below. See the provider directory for Doctor/Clinic Codes.**

8) Applicant's Name (First Name) 9) Last Name

10) Sex  Male  Female 11) Due Date (If Pregnant) 12) Birth Year 13) Social Security Number

14) I wish to **JOIN** or change my plan to: (please select reason for change on the back of the form)

<input type="radio"/> 352 Health Net Comm Solutions	<input type="radio"/> 304 L.A. Care Health Plan
<input type="radio"/> HN Health Net Comm Solutions	<input type="radio"/> BC Anthem Blue Cross Partnrrshp
<input type="radio"/> MO Molina Healthcare Partner	<input type="radio"/> BL Blue Shield Promise
<input type="radio"/> 000 Regular Medi-Cal FFS	<input type="radio"/> LA L.A. Care Health Plan

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**EXAMPLE ONLY – Available plans may vary**

**Choice Statement:** I/We have made written choice to receive Medi-Cal benefits through the plans as I/we have indicated on this form. I/We have read and understand the conditions of this agreement on **both sides**. I/We understand that in order to change my/our current Medi-Cal plan, I/we must complete this form.

 Head of Household or Authorized Representative Signature Date

LA\_0VMFOPS\_ENG\_1225

**Step 6**  
Choose your doctor.

**Step 6a**  
For clinics – Clinic ID, NPI number or Group ID/PPG ID.

**Step 6b**  
Non-clinics/physicians – use NPI number or enrollment ID.

# Provider Selection Guide

## For Clinics

- 1 Go to **www.healthnet.com**.
- 2 Click on *Find a Provider* > Enter City or Zip Code **and** Select **Medi-Cal** under Plan or Network.
- 3 Enter Clinic NPI/Name.
- 4 Fill in the Clinic ID, NPI or Group ID/PPG ID listed on the provider portal (see below example snippet).

**XYZ Clinic**

Provider  
**XYZ Clinic**

Federally Qualified Health Center (Fqhc)

**123 Earth Way CA 93167**

[Accessibility: Basic Access P, EB, IB, R, E \(Verified\)](#)

[29.65 miles away \(view map\)](#)

[999-999-9999](#) | [More contact information](#)

[Show Participating Networks](#) | [Show Details](#)

ADDITIONAL OFFICE LANGUAGES <a href="#">View Details</a>	ADDITIONAL PRACTITIONER LANGUAGES None	AGE LIMITATIONS: 0 yr(s) - 199 yr(s)
CLINIC ID <b>MC0000123</b>	COUNTY Los Angeles	FACILITY ACCREDITATION None
GROUP ID/PPG ID ML661	HOSPITAL QUALITY DATA <a href="#">View Hospital Quality Data Resources</a>	NATIONAL PROVIDER IDENTIFIER <b>1234567890</b>
NURSING HOME COMPARISON TOOL <a href="#">Medicare.gov</a> <a href="#">(new tab)</a>	OPEN WEEKENDS Yes	PATIENT CENTERED MEDICAL HOME No

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[Hide Details](#)

When using the PPG ID, enter the last 4 characters (e.g., ML661 → L661).

# Provider Selection Guide

## For Non-Clinics/Physicians

- 1 Go to **www.healthnet.com**.
- 2 Click on *Find a Provider* > Enter City or Zip Code **and** Select **Medi-Cal** under Plan or Network.
- 3 Enter NPI/Name.
- 4 Fill in the NPI or Enrollment ID listed on the provider portal (see below example snippet).

**Dr. Spider Man**  
Practitioner

**XYZ Medical Group**  
General Practice –Board Certification Unknown; [View Details](#)

**123 Earth Way CA 91367**  
[Accessibility: Details Pending](#)  
0.46 miles away ([view map](#)) | [More locations](#)  
[1-818-888-7009](#) | [More contact information](#)

Accepting new patients  
 In network  
 Primary Care Provider  
 Open now [View hours](#)  
 Offers Virtual Visits  
 Compare

[Show Participating Networks](#) [Show Details](#)

ADDITIONAL OFFICE LANGUAGES None	ADDITIONAL PRACTITIONER LANGUAGES <a href="#">View Languages</a>	AGE LIMITATIONS: 0 yr(s) - 120 yr(s)
COUNTY Los Angeles	ENROLLMENT ID <b>L123456789</b>	FACILITY ACCREDITATION None
GENDER Male	GROUP ID/PPG ID ML1234	HOSPITAL AFFILIATIONS <a href="#">View Hospital Affiliations</a>
LICENSE NUMBER <a href="#">View License Number</a>	NATIONAL PROVIDER IDENTIFIER <b>1234567890</b>	OPEN WEEKENDS Yes
PATIENT CENTERED MEDICAL HOME No	PHYSICIAN ID P123456	

[Rate a Provider](#) | [Reference Information](#) | [Report inaccurate or validate provider information](#)

[Hide Details](#)