



Medi-Cal Choice Enrollment Form Completion Guide

AMADOR, CALAVERAS, INYO, MONO, SACRAMENTO, SAN JOAQUIN, STANISLAUS,
TULARE AND TUOLUMNE COUNTIES



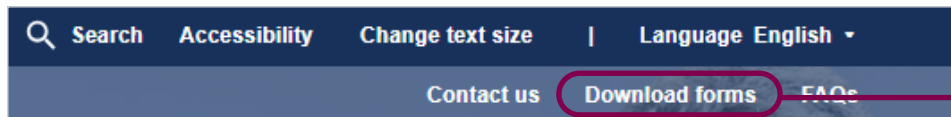


What This Guide Helps You Do

- 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



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 the county selection form. It shows a white dropdown menu with 'Sacramento' selected and a dark blue 'Go' button to its right. Both the dropdown menu and the 'Go' button are circled in red.

Step 2

Select a county 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 Sacramento 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/SA_OVD4103_Eng.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 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)

- 130 Molina Healthcare of CA
- 190 Anthem Blue Cross Partnership
- 150 Health Net Comm Solutions

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.


191 Kaiser Permanente

17) **Program of All-Inclusive Care for the Elderly (PACE):** You may qualify for PACE (see instructions). If you want to enroll in a PACE plan, fill out this option in **addition to section 14**. If you do not qualify for PACE, you will get your care through the plan selected in Section 14.

- 050 Sutter SeniorCare
- 014 Stockton PACE
- 072 Innovage - Sacramento
- 952 Habitat Health Sacramento

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

FR_0MM3451_ENG_0124

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

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 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)

130 Molina Healthcare of CA
 190 Anthem Blue Cross Partnership
 150 Health Net Comm Solutions

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.


191 Kaiser Permanente

17) **Program of All-Inclusive Care for the Elderly (PACE):** You may qualify for PACE (see instructions). If you want to enroll in a PACE plan, fill out this option in **addition to section 14**. If you do not qualify for PACE, you will get your care through the plan selected in Section 14.

050 Sutter SeniorCare
 014 Stockton PACE
 072 Innovage - Sacramento
 952 Habitat Health Sacramento

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

FR_0MM3451_ENG_0124

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

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

[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 View Languages	AGE LIMITATIONS: 0 yr(s) - 120 yr(s)
COUNTY Los Angeles	ENROLLMENT ID L123456789	FACILITY ACCREDITATION None
GENDER Male	GROUP ID/PPG ID ML1234	HOSPITAL AFFILIATIONS View Hospital Affiliations
LICENSE NUMBER View License Number	NATIONAL PROVIDER IDENTIFIER 1234567890	OPEN WEEKENDS Yes
PATIENT CENTERED MEDICAL HOME No	PHYSICIAN ID P123456	

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

[Hide Details](#)