PROVIDERS ONLY INSTRUCTIONS

FOR COMPLETION OF MEDI-CAL CHOICE FORMS
FOR SAN DIEGO COUNTY MEDI-CAL MANAGED CARE
(LIHP TRANSITION)

Beginning November 2013, LIHP (Low Income Health Program) enrollees transitioning to Medi-Cal will begin receiving priority packets by mail informing them of their transition to Medi-Cal managed care. In the priority packet a "Medi-Cal Choice Form" is provided for the beneficiary to complete. This allows the individual to select their Medi-Cal managed care health plan of choice, as well as provides the option of selecting a provider. When assisting the beneficiary keep in mind the following key points:

PRIORITY PACKET:

- Did beneficiary receive the packet? If yes, do they have the Medi-Cal Choice Form that was included?
- If they do not have the the Medi-Cal Choice Form, Provide the patient with a copy of the Choice Form if needed.
- Do they want help completing the Medi-Cal Choice Form? If yes, follow the attached instructions on "Medi-Cal Choice Form Process."
- Instruct the beneficiary/patient to mail the **original** Medi-Cal Choice Form in the pre-paid, pre-addressed envelope provided, and/or the provider can mail at their discretion to County of San Diego, Health and Human Services Agency, P.O. Box 85524, San Diego CA 92186-5524.
    - The beneficiary/patient keeps the pink copy for their records
- Instruct the beneficiary/patient, they must make a Medi-Cal Managed Care Health Plan Choice, fee-for-service is not an option.

If the patient (or provider!) has questions on Medi-Cal managed health care, please call the Healthy San Diego Information Line number at 619-515-6584.

ELECTRONIC COPY OF MEDI-CAL CHOICE FORM:

The Medi-Cal Choice Form can also been found electronically on the Department of Health Care Services website at:
http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Enrollment/Choice_Enrollment_Form.aspx

- The electronic copy is available in English and Spanish.
- Type in the patient's information following the instructions.
- Print out the form for the beneficiary to sign and date (must be an original signature).
- Copy the original for the patient's records.
- Mail the completed form in the prepaid, pre-addressed envelope provided to County of San Diego, Health and Human Services Agency, P.O. Box 85524, San Diego CA 92186-5524.