NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

Enrollment Form

You can use this form to choose or change a health care option and PCP for each person.

0000332948HP

PATRICIA A. JONES
1234 ANY MAIN STREET
RALEIGH, NC 27603-1000

SAMPLE

Choose or change your health care option in one of these ways:

1. Call us toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com)
2. Fill out this form and mail it to us in the envelope provided. Or fax it to 1-833-898-9655.

Person 1	PATRICIA A. JONES, 02/16/1985	ID Number: **XXX-XX-XXXX**
▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the health care option you choose.		
PCP's first and last name or Organization name		PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)		
Do you want this PCP for everyone listed on this form? ☐ Yes ☐ No		
▶ **Choose one health care option.** ☐ EBCI Tribal Option ☐ UnitedHealthcare Community Plan ☐ WellCare ☐ HealthyBlue ☐ AmeriHealth Caritas ☐ Carolina Complete Health		

Person 2		ID Number:
▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the health care option you choose.		
PCP's first and last name or Organization name		PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)		
▶ **Choose one health care option.**		

Person 3		ID Number:
▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the health care option you choose.		
PCP's first and last name or Organization name		PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)		
▶ **Choose one health care option.**		

Questions? Go to ncmedicaidplans.gov. Or call us toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com). We can speak with you in other languages.

You can get free auxiliary aids and services, including information in other languages or formats such as large print or audio. Call us toll free at **1-833-870-5500**.

MEDICAID EB ENROLL FORM EXMEPT | 6 PERSON | ENG 210820

Person 4	ID Number:
▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the health care option you choose.	
PCP's first and last name or Organization name	PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)	
▶ **Choose one health care option.**	

Person 5	ID Number:
▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the health care option you choose.	
PCP's first and last name or Organization name	PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)	
▶ **Choose one health care option.**	

Person 6	ID Number:
▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the health care option you choose.	
PCP's first and last name or Organization name	PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)	
▶ **Choose one health care option.**	

If a Medicaid member is not listed on this Enrollment Form:

- Call us toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com). ***Or***
- Write the member's name and ID number in a blank space on this form. Then choose the member's primary care provider (PCP) and health care option.

Sign and date	
▶ **Head of household or guardian** sign here	Date
▶ **Authorized representative** If you are an authorized representative for this household, fill out this section and sign below.	
Name of authorized representative	Phone number ( )
Address (street, city, state, ZIP Code)	
▶ Authorized representative sign here	Date