NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

Enrollment Form

You can use this form to choose or change a health plan and PCP for each person listed. Or enroll online, using the mobile app, or by phone.

0000332948HP

Patricia A. Jones
17 Main Street
Raleigh, NC 27603

★ **If you are enrolled in NC Medicaid Direct, you <u>do not</u> have to choose a health plan.**

Person 1	Patricia A. Jones, 07/04/88	ID Number: **123-45-6789**

▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the plan you choose.

PCP's first and last 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 plan** (put an X in the box).
☐ WellCare ☐ HealthyBlue
☐ UnitedHealthcare Community Plan ☐ AmeriHealth Caritas

Person 2	Rodney M. Jones, 12/31/88	ID Number: **987-65-4321**

▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the plan you choose.

PCP's first and last name	PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)	

▶ **Choose one health plan** (put an X in the box).
☐ WellCare ☐ HealthyBlue
☐ UnitedHealthcare Community Plan ☐ AmeriHealth Caritas

Person 3		ID Number:

▶ **Choose a primary care provider (PCP).** Make sure the PCP is in the plan you choose.

PCP's first and last name	PCP's phone number (optional) ( )
PCP's address (street, city, state, ZIP Code)	

▶ **Choose one health plan** (put an X in the box).
☐ WellCare ☐ HealthyBlue
☐ UnitedHealthcare Community Plan ☐ AmeriHealth Caritas

Questions? Go to ncmedicaidplans.gov. Or call us at **1-833-870-5500** (TTY: 1-833-870-5588), 7 a.m. to 5 p.m., Monday through Saturday. We can speak with you in other languages.

To get this information in other languages or formats such as large print or audio, call **1-833-870-5500**.

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

▶ **Choose one health plan** (put an X in the box).
☐ WellCare   ☐ HealthyBlue
☐ UnitedHealthcare Community Plan   ☐ AmeriHealth Caritas

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

▶ **Choose one health plan** (put an X in the box).
☐ WellCare   ☐ HealthyBlue
☐ UnitedHealthcare Community Plan   ☐ AmeriHealth Caritas

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

▶ **Choose one health plan** (put an X in the box).
☐ WellCare   ☐ HealthyBlue
☐ UnitedHealthcare Community Plan   ☐ AmeriHealth Caritas

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