NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

Enrollment Form

Use this form to change a health care option and PCP for each person listed. Or enroll online, using the mobile app, or by phone.

0000332948HP

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

SAMPLE

Change your health care option in one of these ways:

1. Go to ncmedicaidplans.gov.
2. Use the free NC Medicaid Managed Care mobile app.
3. Call us toll free at **1-833-870-5500.** (TTY: 711 or RelayNC.com)
4. 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 one health care option.**

☐ WellCare ☐ HealthyBlue ☐ Carolina Complete Health
☐ UnitedHealthcare Community Plan ☐ AmeriHealth Caritas

▶ **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

Person 2	ID Number:

▶ **Choose one health care option.**

▶ **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)	

Person 3	ID Number:

▶ **Choose one health care option.**

▶ **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)	

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**.

Person 4	ID Number:
▶ **Choose one health care option.**	
▶ **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)	

Person 5	ID Number:
▶ **Choose one health care option.**	
▶ **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)	

Person 6	ID Number:
▶ **Choose one health care option.**	
▶ **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)	

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 health care option and primary care provider (PCP).

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