



Enrollment Form

Use this form to change a health care option and PCP for each person.



0000332948HP

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

SAMPLE

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	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)	
Do you want this PCP for everyone listed on this form? <input type="checkbox"/> Yes <input type="checkbox"/> 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