



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
1234 ANY MAIN STREET
RALEIGH, NC 27603-1000

SAMPLE

Choose or change your health plan in one of these ways:

1. Go to ncmedicaidplans.gov.
2. Use the free NC Medicaid Managed Care mobile app.
3. Call us at **1-833-870-5500** (TTY: 1-833-870-5588).
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 a primary care provider (PCP). Make sure the PCP is in the health 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
▶ Choose one health plan.		
<input type="checkbox"/> WellCare <input type="checkbox"/> HealthyBlue <input type="checkbox"/> UnitedHealthcare Community Plan <input type="checkbox"/> AmeriHealth Caritas		
Person 2		ID Number:
▶ Choose a primary care provider (PCP). Make sure the PCP is in the health 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.		
Person 3		ID Number:
▶ Choose a primary care provider (PCP). Make sure the PCP is in the health 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.		

Questions? Go to ncmedicaidplans.gov. Or call us at **1-833-870-5500** (TTY: 1-833-870-5588).
The call is free. 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 health 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.	
Person 5	ID Number:
▶ Choose a primary care provider (PCP). Make sure the PCP is in the health 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.	
Person 6	ID Number:
▶ Choose a primary care provider (PCP). Make sure the PCP is in the health 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.	

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

- Call us at **1-833-870-5500** (TTY: 1-833-870-5588), *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 plan.

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