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
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? ☐ Yes ☐ No		
▶ **Choose one health plan.** ☐ EBCI Tribal Option ☐ UnitedHealthcare Community Plan ☐ WellCare ☐ HealthyBlue ☐ 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