Dear Employee or Retiree:

Please complete the Information Card below to select a PCP or if you are a current POS member, you may contact customer service or visit www.carefirst.com/statemd to change your PCP selection. Detach this informational record at the perforation below and mail the Information Card **DIRECTLY** to CareFirst BlueCross BlueShield (CareFirst) (there is no postage due). This Information Card will assist us in processing your enrollment. **By filling out this form, you select your own PCP. If you do not complete and return it, all services will be processed as out of network subject to deductible and coinsurance.**

Your permanent Point of Service ID card(s) will be forwarded to you upon CareFirst's receipt of this form.

If you have questions, please do not hesitate to call Customers Services Department at 410-581-0021 between 8:00 a.m. and 8:00 p.m., Monday through Friday and between 8:00 a.m. and 1:00 p.m. on Saturday. Our representatives will be happy to assist you with any inquiry.

When selecting your PCP, refer to the online directory at **www.carefirst.com/statemd.**

STATE OF MARYLAND – POINT OF SERVICE PRIMARY CARE PHYSICIAN SELECTION CARD

FOR PCP SELECTION ONLY

TYPE OF NOTICE (Check One)
- ☐ NEW HIRE EMPLOYEE
- ☐ OPEN ENROLLMENT CHANGE

EMPLOYMENT STATUS (Check One)
- ☐ ACTIVE
- ☐ RETIREE
- ☐ COBRA

COVERAGE TYPE (Check One)
- ☐ Individual ☐ Husband/Wife
- ☐ Parent/Child ☐ Family

LAST NAME	FIRST NAME	M.I.

STREET ADDRESS (INCLUDE APT. NO. OR P.O. BOX NO.)

CITY	STATE	ZIP CODE

HOME PHONE NUMBER	BUSINESS PHONE NUMBER	DATE OF BIRTH	SEX
( )	( )	/ /	☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER	PRIMARY CARE PHYSICIAN SELECTION (Refer to Maryland POS Directory)+	PCP #	EXISTING PATIENT?
– –			☐ YES ☐ NO

After your MARYLAND POINT OF SERVICE coverage begins, will you or any eligible dependents be covered by any other insurance (including Medicare)? ☐ YES ☐ NO
If yes, complete below:

Insurance Co. Name: ______________ Insurance Effective Date: ______________

Policy Number: ______________ Policyholder Name: ______________

Insurance Co. Address: ______________ Policyholder Date of Birth: ______________

LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED BY MARYLAND POINT OF SERVICE

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR.	M OR F	Existing Patient	PRIMARY CARE PHYSICIAN SELECTION NAME	PCP#
Spouse				– –	/ /		☐Yes ☐No		
Child				– –	/ /		☐Yes ☐No		
Child				– –	/ /		☐Yes ☐No		
Child				– –	/ /		☐Yes ☐No		
Child				– –	/ /		☐Yes ☐No		
Child				– –	/ /		☐Yes ☐No		

If any dependent's ADDRESS is different, please indicate dependent's full name and the correct address: ______________

If any dependent's LAST NAME is different, please explain relationship to subscriber: ______________

POLICYHOLDER (Subscriber) SIGNATURE ______________ **Date** ______________

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®′ Registered trademark of CareFirst of Maryland, Inc.

Return to:

State of Maryland Enrollment
Maryland Point of Service
Mail Stop 02-250
10455 Mill Run Circle
Owings Mills, MD 21117