

**Dear Employee or Retiree:**

Please complete the Information Card below to select a PCP or if you are a current CareFirst BlueChoice (BlueChoice) member, you may contact customer service or visit [www.carefirst.com/statemd](http://www.carefirst.com/statemd) to change your PCP selection. Detach this informational record at the perforation below and return the Information Card (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 this form you will not have a PCP provider listed on your ID card.**

Your permanent BlueChoice HMO ID card(s) will be forwarded to you upon our receipt of this form.

If you have questions, please do not hesitate to call Member Services Department at 410-654-8675 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](http://www.carefirst.com/statemd).



**STATE OF MARYLAND – CAREFIRST BLUECHOICE HMO  
PRIMARY CARE PHYSICIAN SELECTION CARD  
FOR PCP SELECTION ONLY**

<b>TYPE OF NOTICE (Check One)</b> <input type="checkbox"/> NEW HIRE EMPLOYEE <input type="checkbox"/> OPEN ENROLLMENT CHANGE	<b>EMPLOYMENT STATUS (Check One)</b> <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIREE <input type="checkbox"/> COBRA	<b>COVERAGE TYPE (Check One)</b> <input type="checkbox"/> Individual <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Parent/Child <input type="checkbox"/> 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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
SOCIAL SECURITY NUMBER _____	PRIMARY CARE PHYSICIAN SELECTION (Refer to BlueChoice Directory)+ _____	PCP # _____ EXISTING PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
After your BLUECHOICE coverage begins, will you or any eligible dependents be covered by any other insurance (including Medicare)? <input type="checkbox"/> YES <input type="checkbox"/> 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 BLUECHOICE HEALTH PLAN**

	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO. DAY YR.	M OR F	Existing Patient	PRIMARY CARE PHYSICIAN SELECTION
							<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME PCP#
Spouse				-     -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME PCP#
Child				-     -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME PCP#
Child				-     -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME PCP#
Child				-     -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME PCP#
Child				-     -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME PCP#
Child				-     -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	NAME PCP#

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**

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State of Maryland Enrollment  
CareFirst BlueChoice  
Mail Stop 02-330  
10455 Mill Run Circle  
Owings Mills, MD 21117

Return to:

