CareFirst BlueCross BlueShield
Community Health Plan Maryland
Attention: Enrollment Department
PO Box 915
Owings Mills, MD 21117
FAX: 410-849-0616

Primary Care Provider Acceptance Form

Please complete this form and submit by mail or fax. All information is required.

Section 1 – Patient Information		
Member Name:		Member/Recipient ID #:
Member Address:		
City:	State:	Zip Code:
Member Phone #:		DOB:
Signature of Patient/ Parent/Guardian:		

Section 2 – Provider Information
Provider's Site/Name:
National Provider Identification:
Please change PCP effective (date):

Section 3 – Office Manager Information	
Name:	
We accept this member into our panel. Yes [ ] No [ ]	
Office Phone #:	Office Fax #:
Signature of Office Manager:	Date:

If you have any questions, please email our Provider Relations Department at providerMD@CareFirst.com.

www.CareFirstchpmd.com