Montgomery County Public Schools

CareFirst BlueChoice

RESET

PRINT

CAREFIRST BLUECHOICE PLAN (HMO)
PRIMARY CARE PHYSICIAN SELECTION FORM

1 MEMBER INFORMATION

EMPLOYEE/MEMBER APPLICANT LAST NAME | FIRST NAME | MIDDLE INITIAL | SOCIAL SECURITY NUMBER

__ __ __ / __ __ / __ __ __ __

2 SPOUSE/CHILD AND PRIMARY CARE PHYSICIAN INFORMATION

LIST ELIGIBLE SPOUSE AND / OR CHILD TO BE COVERED LAST NAME FIRST M.I.	RELATIONSHIP	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PCP ID NUMBER	PRIMARY CARE PHYSICIAN
	EMPLOYEE/ APPLICANT					☐ CURRENT PATIENT
	SPOUSE					☐ CURRENT PATIENT
	CHILD					☐ CURRENT PATIENT
	CHILD					☐ CURRENT PATIENT
	CHILD					☐ CURRENT PATIENT
	CHILD					☐ CURRENT PATIENT
	CHILD					☐ CURRENT PATIENT
	CHILD					☐ CURRENT PATIENT

3 OTHER HEALTH INSURANCE INFORMATION (to be completed if applicable)

NOTE: THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE THIS SECTION MAY DELAY CLAIMS PAYMENT.

ARE YOU, YOUR SPOUSE, OR ANY LISTED CHILDREN COVERED BY ANY OTHER HEALTH INSURANCE OR ANOTHER BLUE CROSS AND BLUE SHIELD PLAN? ☐ YES ☐ NO

IF YES:

NAME OF POLICY HOLDER | POLICY NUMBER

INSURANCE COMPANY | CITY AND STATE

DOES THIS POLICY COVER YOU? ☐ YES ☐ NO

YOUR SPOUSE? ☐ YES ☐ NO

YOUR CHILDREN? ☐ YES ☐ NO

EMPLOYEE'S/MEMBER'S SIGNATURE | DATE

PLEASE RETURN ONE COPY OF THE COMPLETED FORM TO THE EMPLOYEE AND RETIREE SERVICE CENTER