



An Independent Licensee of the Blue Cross and Blue Shield Association

Failure to fill out this application completely may result in a delay of coverage.

Primary Care Physician (PCP) Selection Form

Use this form to elect your Primary Care Physician.

Shaded area completed by Employer: Group/Billing Unit No. _____ Group Department No. _____ Effective Date _____
 Employer Name: _____ Employer Address: _____

A. Employee Information

Name (First, Last): _____ Social Security Number: _____

Address: _____

City, State, Zip: _____

Telephone: () _____

B. PCP Selection

- A primary care provider must be chosen for each family member; females may also select a participating OB/GYN. (If an OB/GYN is not selected, your PCP should provide these services.)
- You may change your PCP or OB/GYN by submitting this form or calling the customer service number on your ID card. PCP election changes will be effective the first of the month following receipt of your request.

Full Name (First, Last)	Date of Birth MM-DD-YY	Sex (Check one)	Provider Number	PCP Name (First and Last Name)	PCP Address (Office location where you will receive services)	Are you an established patient?	OB/GYN Provider Number (if enrollee is female)	OB/GYN PCP Name (if enrollee is female)	OB/GYN PCP Address (if enrollee is female)	Are you an established patient?
Self		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent		<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Signature _____

Date ____ / ____ / ____