CareFirst
Community Health Plan
District of Columbia

CAREFIRST CHPDC PCP DESIGNATION FORM

I, _____ am a patient who agrees to be seen for
(Enrollee Name)
Medical services at the following clinic/provider office:

_____

I have been assigned to **CareFirst CHPDC** and my Enrollee ID number is:

_____

I would like _____ to be my Primary Care Provider (PCP), effective: _____.

I, _____ as the enrollee understand that by requesting this PCP assignment that I will continue to seek and receive care from my PCP until I officially request a PCP change by contacting the health plan indicated above. This change will result with a new enrollee ID card being issued.

Please complete the contact information below to ensure that your card is mailed to your current residence or if homeless, clinic where services are obtained.

_____ _____
Print Enrollee Name Date of Birth

_____ _____
Enrollee Signature Date of Signature

_____
Enrollee Home Address: House Number, Street Name and Apt # (If applicable)

_____ _____ _____ _____
City State Zip Telephone #

_____ _____ _____ _____
Witness Signature Witness Name Name & Telephone # Date

Please fax the form
to: CareFirst CHPDC
Attn: Enrollment
202-821-1098

CareFirst Community Health Plan District of Columbia

Clinic/Provider Office

Enclosures: Non-Discrimination & Language Taglines

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