Case #_____
Dist. # _____

# CCNC/CA Enrollment Form

Date: _____ County: _____ Fax: _____ Person Completing Form: _____

Case Head: _____MID_____ Preferred Language: _____
Address:

_____
Street City Zip

Telephone #: _____ Cell # _____ Email: _____

| | Person to be Enrolled | Date of Birth | MID | Name of primary care provider | Provider ID or Exempt Code |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

If requesting a temporary exemption for anyone above, write the recipient's number and provide a detailed reason for the request. Attach additional paper if necessary.

_____

_____

_____

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☐ Handbook provided at time of interview
☐ Handbook mailed to Case head
☐ NCHC- "Benefits of Being a Member" handbook provided to case head

SIGNATURE OF PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A MINOR:

_____ DATE: _____
***(By signing, I certify that I have received an explanation of CCNC/CA and have been given the opportunity to choose a participating medical home)***

***FOR STATE USE ONLY***

☐ Exemption Denied ☐ Exemption Approved Exempt Code: _____

DMA- 9006
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Division of Medical Assistance
Community Care of North Carolina/Access Care
DMA Fax 919-715-5235