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	Medicaid/NCHC ID	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 ID number and provide a detailed reason for the request. Attach additional paper if necessary.

_____

_____

_____

(Medicaid)

❑ CCNC/CA Handbook provided at time of interview.
❑ CCNC/CA Handbook mailed to Case head.
❑ "CCNC/CA: The Benefits of Being a Member-Medicaid" Handout (Figure 12a) provided at time of interview.
❑ "CCNC/CA: The Benefits of Being a Member-Medicaid" Handout (Figure 12a) mailed to Case head.

(NCHC)

❑ "The Benefits of Being a Member-NCHC" Handout (Figure 12b) provided at time of interview.
❑ "The Benefits of Being a Member-NCHC" Handout (Figure 12b) mailed 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: _____

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

DMA- 9006
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