

# Enrollment Form

Use this form to choose a Health Plan and a primary care provider (PCP) for each person listed. If you don't choose a PCP, the Plan will choose one for you. It is best to make your own choice!



Barcode1  
CaseCIN

[<Head of Household Name>  
<Address 1>  
<Address 2>  
<City>, <State> <ZIP Code>]

## Enroll by ResponseDate. Here are the 5 ways you can enroll:

1. Enroll online at [www.bayouhealth.com](http://www.bayouhealth.com)
2. Call us at **1-855-BAYOU-4U** (1-855-229-6848). The call is free.
3. Fill out this form and send it to us in the return envelope.
4. Complete this form and fax it to 1-888-858-3875.
5. Enroll in person at your local Medicaid eligibility office.

### ► If the above name and address are not correct, write the correct information here.

|             |            |           |
|-------------|------------|-----------|
| First name: | Last name: |           |
| Address:    |            |           |
| City:       | State:     | ZIP Code: |

### ► What is the best number we can use to call you? Home: (     ) Cell: (     )

### ► If a provider or someone at your provider's office assisted you with enrolling, have them complete the following:

|                             |                           |
|-----------------------------|---------------------------|
| Provider/Practitioner name: | Group/Organization name:  |
| Plan affiliations:          | Telephone number: (     ) |

|            |                             |
|------------|-----------------------------|
| MemberName | Card control number: Number |
|------------|-----------------------------|

### Choose one Health Plan (put an X in the box).

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Amerigroup                       | <input type="checkbox"/> Community Health Solutions      | <input type="checkbox"/> AmeriHealth Caritas Louisiana |
| <input type="checkbox"/> Louisiana Healthcare Connections | <input type="checkbox"/> UnitedHealthcare Community Plan | <input type="checkbox"/> Regular Medicaid              |

### Choose a PCP Is this your current PCP? Yes No

|  |                             |
|--|-----------------------------|
| PCP's first and last name:                     | PCP's phone number: (     ) |
| PCP's address (street, city, state, ZIP Code): |                             |

|                      |
|----------------------|
| Card control number: |
|----------------------|

### Choose one Health Plan (put an X in the box).

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Amerigroup                       | <input type="checkbox"/> Community Health Solutions      | <input type="checkbox"/> AmeriHealth Caritas Louisiana |
| <input type="checkbox"/> Louisiana Healthcare Connections | <input type="checkbox"/> UnitedHealthcare Community Plan |  |

### Choose a PCP Do you want the same PCP that you chose for the first member? Yes No *If Yes, skip to the next member. If No, please tell us about the PCP.* Is this your current PCP? Yes No

|  |                             |
|--|-----------------------------|
| PCP's first and last name:                     | PCP's phone number: (     ) |
| PCP's address (street, city, state, ZIP Code): |                             |

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Please turn the page ►►►



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