



Select a Primary Care Provider (PCP) today!



We want you to get the most out of your medical plan. If you are a CareFirst BlueCross BlueShield (BCBS) Point of Service (POS) In-Service Area Plan, you need to select a PCP for yourself and your covered family members. Not selecting a PCP can significantly impact the benefits you receive:

When you select a PCP	When you do <u>not</u> select a PCP
<ul style="list-style-type: none"> ✓ Your benefits are covered at the in-network level whenever you see a participating provider, which means your out-of-pocket expenses are <i>lower</i>. ✓ You do not need to file a claim for in-network services. 	<ul style="list-style-type: none"> ➔ Your benefits are covered at the out-of-network level, <i>even if you see a participating provider</i>, which means your out-of-pocket expenses are <i>higher</i>. ➔ Generally, you must file a claim for most services when using an out-of-network provider.

For details about in-network and out-of-network benefits, please see the Medical Plan Comparison chart (part of the Group Insurance Summary Description).

Action required:

1. **Find a participating PCP.** Visit www.carefirst.com and select the link under "Find a Provider." Then, search for PCPs in the Maryland POS or BlueChoice networks and jot down the PCP's name and ID number.
2. **Contact CareFirst BCBS to select a PCP for you and each covered family member.** You have two options:
 - Call CareFirst BCBS toll-free at 1-888-417-8385 and inform the customer service representative of your PCP's name and ID number.
 - Complete the attached form and fax it to the number on the form.
3. **Review the new ID card(s) that will be mailed to you by the end of January.** If your PCP's name does not appear on the card, call CareFirst BCBS toll-free at 1-888-417-8385.

–Your OHR Health Insurance Team



Primary Care Provider (PCP) Selection Form

for BlueCross BlueShield Point of Service (POS)

A PCP is required to access in-network benefits.
 This form is not required for POS Out-of-Area members or Medicare-eligible retirees.

1. Member Information							
Member Last Name			First Name			MI	Social Security Number

2. Spouse/Child and Primary Care Provider (PCP) Information							
LAST NAME	FIRST	MI	RELATIONSHIP	SEX	DATE OF BIRTH	PCP ID NUMBER	PCP NAME
			Member				<input type="checkbox"/> Current Patient
			Spouse				<input type="checkbox"/> Current Patient
			Child				<input type="checkbox"/> Current Patient
			Child				<input type="checkbox"/> Current Patient
			Child				<input type="checkbox"/> Current Patient
			Child				<input type="checkbox"/> Current Patient
			Child				<input type="checkbox"/> Current Patient
			Child				<input type="checkbox"/> Current Patient
			Child				<input type="checkbox"/> Current Patient

3. Other Health Insurance Information (to be completed if applicable)			
NOTE: THIS INFORMATION IS SUBJECT TO VERIFICATION. FAILURE TO COMPLETE THIS SECTION MAY DELAY CLAIMS PAYMENT. Are you, your spouse, or any listed children covered by any other health insurance or another Blue Cross and Blue Shield plan?			<input type="checkbox"/> Yes <input type="checkbox"/> No
IF YES:	Name of Policy Holder	Policy Number	Does this policy cover you? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Insurance Company	City and State	Your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No
			Your children? <input type="checkbox"/> Yes <input type="checkbox"/> No
Member Signature			Date

**FAX FORM DIRECTLY TO CAREFIRST:
 443-753-2380**