WVCHIP MEDICAL HOME PROGRAM

Medical Home Physician Selection Form

Guardian Name _____ Guardian ID _____
Address _____ Daytime Phone _____
City, State Zip _____

Covered Individual	Date of Birth	Member ID	Medical Home Provider NPI

Comments

GUARDIAN's SIGNATURE: _____ DATE: _____

Coverage in the Medical Home Program will not start until the first day of the month after we get this form.

Please return this form to: Molina Medicaid Solutions
PO Box 3732
Charleston, West Virginia 25337

Or FAX to (304) 340-2763

If you have any questions, please call Molina Benefit Solutions toll-free at 1-800-479-3310.