WVCHIP MEDICAL HOME ENROLLMENT FORM

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 Name and NPI

Comments

GUARDIAN'S SIGNATURE: _____ **DATE:**_____

***If you do not have your provider's NPI number, please include their full name and address.**

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

Please return this form to:

DXC Technology
PO Box 2673
Charleston, West Virginia 25301-2673

Or FAX to (304) 340-2763