Access+ HMO

federal employees health benefits program
Primary Care Physician Selection Form

First Name | MI | Last Name

Address

Phone Number | Social Security Number | Date of Birth

Please complete this Primary Care Physician Selection Form in order to expedite processing of your membership and the issuance of your Access+ HMO® identification cards.

Access+ HMO enrollees must select a primary care physician within their plan service area and listed in the *Blue Shield Access+ HMO Physician and Hospital Directory*. You may choose the same or a different Access+ HMO primary care physician for each family member. Check the "current patient" box if the primary care physician selected is currently your physician. Be sure to include each primary care physician's identification number, his or her affiliated Independent Practice Association (IPA) or medical group name and the IPA/medical group identification number. Please refer to the *Blue Shield Access+ HMO Physician and Hospital Directory for Federal Employees* for this information. If you do not select a primary care physician, Blue Shield will assign one to you. If you need assistance, please call Member Services at **(800) 880-8086**. In order to enroll in the FEHBP, you must also complete the electronic enrollment process or an SF 2809 Health Benefits Registration Form and return it to your personnel office. **Please include a copy of your electronic enrollment confirmation or the SF 2809 when you return this form.**

Mail to: Blue Shield of California
Membership – Confidential
PO Box 629014
El Dorado Hills, CA 95762-9975

Self	Primary Care Physician Name		Provider No.		IPA/MG Name	IPA/MG No. ☐ Check if current patient
Spouse	☐ Male ☐ Female	First Name	MI	Last		Date of Birth
	Primary Care Physician Name		Provider No.		IPA/MG Name	IPA/MG No. ☐ Check if current patient
Child	☐ Male ☐ Female	First Name	MI	Last		Date of Birth
	Primary Care Physician Name		Provider No.		IPA/MG Name	IPA/MG No. ☐ Check if current patient
Child	☐ Male ☐ Female	First Name	MI	Last		Date of Birth
	Primary Care Physician Name		Provider No.		IPA/MG Name	IPA/MG No. ☐ Check if current patient
Child	☐ Male ☐ Female	First Name	MI	Last		Date of Birth
	Primary Care Physician Name		Provider No.		IPA/MG Name	IPA/MG No. ☐ Check if current patient