BlueCross BlueShield of Illinois

HMO/CPO Provider Selection

Enrollment and Change Form

Please print clearly in ink. This form should be used to complete your Blue Cross and Blue Shield of Illinois (BCBSIL) HMO or CPO coverage enrollment and is required in addition to the Illinois Standard Health Employee Application. This form can also be used to change your HMO providers or CPO network selections. Please complete all sections for yourself, your spouse/domestic partner and your dependents. If more space is required, a copy of this form or a separate piece of paper may be attached.

If You Are Enrolling/Changing HMO Coverage

- You must select a Medical Group or IPA (Independent Practice Association) and a Primary Care Physician (PCP) for each person to be covered.
- Please enter the name and numbers for both the Medical Group/IPA selection and the PCP selection for each person. If available, also enter the National Provider Identification (NPI) number.
- The Medical Group/IPA number is 3 digits. The PCP number is 9 digits. The NPI number is 10 digits.
- The PCP selected must be from within your Medical Group/IPA.
- You may choose a different Medical Group/IPA for each person.
- Female members may also choose a Woman's Principal Health Care Provider (WPHCP) from within your Medical Group/IPA. A WPHCP may be seen for care without referrals from your PCP, however, the WPHCP must be affiliated with or employed by your Medical Group/IPA.
- Medical Group/IPA, PCP, WPHCP and NPI provider information can be found using the Provider Finder® tool on *bcbsil.com*.
- Until we receive this information, you are not eligible to receive medical services and your claims could be denied.

If You Are Enrolling/Changing CPO Coverage

- You must select a CPO Network that will apply to all persons being covered.
- Please enter the name and number of the CPO Network
- The CPO Network number is 3 or 4 characters: the letters "CO" followed by 1 or 2 digits.
- CPO Network information can be found using the Provider Finder tool on *bcbsil.com*.

For HMO/CPO Coverage

- If you are already enrolled and only **changing** your provider or network selection, enter your Group and Member Identification numbers found on your BCBSIL ID card.
- Sign and date this form on page 2.

Employer Name _____ **Member ID Number** _____

Group/Section # _____ **Effective Date** _____

Employee Name (Last) _____ (First) _____ (MI) _____

Social Security Number: | Date of Birth: / /

Medical Group/IPA # __ __ __ Medical Group/IPA Name: _____

PCP # __ __ __ __ __ __ __ __ __ PCP Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

CPO Network # C O __ __ CPO Network Name: _____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

Social Security Number: | Date of Birth: / /

Medical Group/IPA # __ __ __ Medical Group/IPA Name: _____

PCP # __ __ __ __ __ __ __ __ __ PCP Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

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Dependent Name (Last) ______________________ (First) ______________________ (MI) ______

Social Security Number: | Date of Birth: / /

Medical Group/IPA # ___ ___ ___ Medical Group/IPA Name: ______________________

PCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Dependent Name (Last) ______________________ (First) ______________________ (MI) ______

Social Security Number: | Date of Birth: / /

Medical Group/IPA # ___ ___ ___ Medical Group/IPA Name: ______________________

PCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Dependent Name (Last) ______________________ (First) ______________________ (MI) ______

Social Security Number: | Date of Birth: / /

Medical Group/IPA # ___ ___ ___ Medical Group/IPA Name: ______________________

PCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Dependent Name (Last) ______________________ (First) ______________________ (MI) ______

Social Security Number: | Date of Birth: / /

Medical Group/IPA # ___ ___ ___ Medical Group/IPA Name: ______________________

PCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP # ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ______________________ NPI # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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Employee Signature **Date**