

Check box if you need assistance finding an in-network Primary Care Physician and a Care Coordinator will call you.



You will receive two ID cards upon enrollment. If you need additional cards, check the amount below:

2 extra cards 4 extra cards

Please complete and return this form directly to Quantum Health using the enclosed "Coordinated Health/Care" self-addressed stamped envelope

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

I authorize the release of information, including historic claims data, from any medical/medically-related provider, government agency or person for the purpose of: (i) adjudicating claims submitted on behalf of me or my dependents as long as I am covered under this Plan; (ii) implementing the care coordination process utilized under the Plan to monitor healthcare services or quality improvement activities; and (iii) credentialing providers. I further acknowledge that I have been provided a copy of the Plan's HIPAA Privacy Notice (back of this form). I authorize photocopies of this release to be provided to any physician or medical institution to obtain records for the purposes stated above. I further understand that a misrepresentation on this form may result in ineligibility for benefits.

Employee Signature _____

Date _____

PRIMARY CARE PHYSICIAN (PCP) DESIGNATION FORM

Check Box on Reason for the Form:	Employee Name: _____ Employee Home Phone Number: _____
<input checked="" type="checkbox"/> Initial Designation of PCP - Effective upon enrollment	<p>"Primary Care Physician" or "PCP" means a physician who specializes in family practice, internal medicine or pediatrics. Complete the information below for you and all eligible family members who are listed on the front of this form for coverage under the <i>MATC Coordinated Health/Care™</i> program. PLEASE PRINT CLEARLY and include both the first and last name of the primary care physician you list.</p> <p>If you are not a current patient of the Primary Care Physician you have designated, you must verify with each Primary Care Physician that he or she is taking new patients at this time. If you need assistance in establishing a relationship with a Primary Care Physician, please contact a <i>Care Coordinator</i> at 1-866-521-0153 for assistance or visit your plan website at www.MATCHealthPlan.com.</p>
<input type="checkbox"/> Change Designation of PCP - Effective on the 1 ST of the month following receipt	
<input type="checkbox"/> Designation of PCP for New Family Member - Effective upon eligibility	

Insured Name:	Primary Care Physician (PCP) Full Name:		Primary Care Physician (PCP) Address:				PCP Phone Number:	New Patient?
Insured Employee Name:	Last Name	First Name	Street Address	City	State	Zip		<input type="checkbox"/> Yes <input type="checkbox"/> No
Insured Dependent #1 Name:	Last Name	First Name	Street Address	City	State	Zip		<input type="checkbox"/> Yes <input type="checkbox"/> No
Insured Dependent #2 Name:	Last Name	First Name	Street Address	City	State	Zip		<input type="checkbox"/> Yes <input type="checkbox"/> No
Insured Dependent #3 Name:	Last Name	First Name	Street Address	City	State	Zip		<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: If you have more than 3 eligible dependents covered under the Plan, please complete other side of this form. ↘