Primary Care Provider (PCP) selection form

Please choose a Primary Care Provider (PCP) for each person who is a member of Passport by Molina Healthcare. Write down the PCP's name and street address in the space below. If all the children in your family see the same PCP, you only need to write in that PCP's name and address one time.

Member Name	Member ID Number	PCP's Name	PCP's Street Address

Other insurance

Are you or any members of your household covered by any other insurance company?

☐ Yes ☐ No

If you checked off "No", go to the next question.

If you checked off "Yes" please write down the name of the insurance company by each person who has other coverage with that company. Also, if you have a card from the other insurance company, please write down the policy number or group number on the card.

Member Name	Insurance Company Name	Policy/Group Number

Are you or any members of your household covered by Medicare? ☐ Yes ☐ No

If you checked off "No", you do not need to fill anything else out on this form. **Mail this form back to us in the envelope provided. You do not need a stamp.**

If you checked off "Yes" please write down the names of the people who are covered by Medicare

Member Name	Member Name	Member Name

Please fill in your current phone number: _____ Email:_____

Thank you,
Passport by Molina Healthcare
(800) 578-0603

PASSPORT
BY MOLINA HEALTHCARE