



Today's Date _____ Name of staff completing form: _____

Member's Name: _____

Member's Medicaid #: _____ and Social Security #: _____

Member's Address: _____

Phone number where member can be reached (write none if no phone): _____

Full name of Total Carolina Care PCP number is selecting for baby:

Address of PCP _____

PCP ID number _____

Mother's estimated due date: _____

Mother's signature: _____

If PCP panel is full, PCP must sign below authorizing the addition to his/her panel.

PCP Signature _____ Date _____