Washington State Health Care Authority

Client ID Number:
Name:
Address:

Enrollment Form

Easy as 1-2-3!

1. Please mark one box to show how you want to get health care for the people in your family.

- ☐ Amerigroup Washington Inc. (AMG)
- ☐ Community Health Plan of Washington (CHPW)
- ☐ Coordinated Care of Washington (CCW)
- ☐ Molina Healthcare of Washington Inc. (MHW)
- ☐ United Health Care Community Plan (UHC)
- ☐ FEE FOR SERVICE
- ☐ PCCM CLINIC _____

2. Write the name of the doctor or clinic you would like for each person. All doctors and clinics you list must be in the plan you choose above. Call the doctors to see if they are with the health plan.

Client ID	Client Name (Last, First, MI)	How would you rate this person's Health? Excellent	Very Good	Good	Fair	Poor	Special Health Condition or Developmental Delay? Yes	No
Doctor or Clinic:		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								

3. Is anyone above pregnant or having surgery?

☐ Pregnant Family Member's Client ID: _____ Due Date: _____

Doctor or clinic: _____

☐ Scheduled for surgery Family Member's Client ID: _____ Date: _____

Signature _____ **Date** _____

Choose ONE way to let us know your choice.

- Sign up on line: **https://www.WAProviderOne.org/client**
- Call our automated system anytime: 1-800-562-3022
- Fill out and mail to: Washington State Health Care Authority, PO Box 42719, Olympia, WA 98504
- Fill out and then fax to: **1-866-668-1214**

If you have questions call 1-800-562-3022, Monday – Friday 7:30 a.m. to 5:00 p.m.
TTY/TDD users call 711 or 1-800-848-5429

Provider One Number