CareFirst BlueCross BlueShield

CareFirst BlueChoice

Enrollment Transaction Report

Please Print All Information

Group Number: _____ **Date:_____**

Group Name: _____

Group Location: DC ☐ MD ☐ VA ☐ OTHER ☐

Group Administrator: _____

Group Administrator Phone Number: _____

ATTENTION: APPLICATIONS MUST BE INCLUDED WITH ALL ADDITIONS, REINSTATEMENTS AND CHANGES IN COVERAGE

Check Appropriate Column

NAME	SOCIAL SECURITY NUMBER	ADD	DELETE	CHANGE	EFFECTIVE DATE	REMARKS	FOR INTERNAL USE ONLY IACS NUMBER

Please return this form to:

CareFirst BlueCross BlueShield/CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065
Attention: Account Implementation Department
Mailstop 31

CUT5795-1S (6/03)