Neighborhood Health Plan™

Enrollment and Change Form

253 Summer Street, Boston, MA 02210-1120

Tel 800-462-5449
Fax 617-526-1981

Application for Enrollment
- ☐ New employee
- ☐ Annual enrollment
- ☐ COBRA Continuation
- ☐ Involuntary loss of prior group coverage*
- ☐ Other ____________

**Documentation required*

Change in Enrollment
- ☐ Adding dependents
- ☐ Deleting dependents
- ☐ PCP/Site change
- ☐ Termination
- ☐ Employee/dependent demographics
- ☐ Other ____________

Reason for Change in Enrollment
- ☐ Marriage
- ☐ Birth of child
- ☐ Adoption of child*
- ☐ Divorce
- ☐ Left employment
- ☐ Reached age 65
- ☐ Adding disabled dependents
- ☐ Moved out of service area
- ☐ Voluntary
- ☐ Loss of dependent eligibility
- ☐ Death, exact date ________

Please use a ball point pen and press down firmly.

Group Information

NHP group number		Employer name			
Date of employment	Month / Day / Year	Effective Date	Month / Day / Year	Plan design	

Employee Information

Last name			First name		M.I.
Date of birth (mm/dd/yy)	Social Security Number		Gender (m/f)	Home phone – *Include area code*	Work phone – *Include area code*
Street mailing address	Apt.	P.O. Box	City	State	Zip code

PCP and Site Information

If the Primary Care Physician (PCP) you choose is not in the NHP network, one will be selected for you. For help finding a PCP, please go to nhp.org and use our Provider Search Tool under the “Find a Provider” link. You may change your PCP assignment at any time.

Primary care site	
Your Primary Care Physician (Last name, First, M.I.)	Existing patient? ☐ Yes ☐ No

Language

What language do you speak most often? Please check (✓) the appropriate box. Knowing the main language spoken by you and your family members will help us to better serve your needs.

☐ English (04) ☐ Spanish (14) ☐ French (05) ☐ Haitian Creole (06) ☐ Portuguese (12) ☐ Russian (13) ☐ Cape Verdean Creole (03) ☐ Cantonese (02) ☐ Mandarin (11) ☐ Vietnamese (15) ☐ Other (16), please specify____________

Group Coverage

Type of NHP coverage (check only one)	In addition to NHP, my spouse or children are covered by a health plan offered by:			
☐ Self ☐ Individual & spouse ☐ Individual & child/children ☐ Family	Employer	Insurance co. name	Policy #	Effective date

Are you and/or your spouse eligible for Medicare?				
	Self ☐ Yes ☐ No	If yes, are you enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your Medicare policy number
	Spouse ☐ Yes ☐ No	If yes, is your spouse enrolled in	☐ Medicare Part A ☐ Medicare Part B	Your spouse's Medicare policy number

Please provide **ALL** information below for any eligible dependents you wish to enroll.

Spouse last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number**	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number**	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number**	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number**	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Dependent last name		First name		M.I.	Primary care site	Existing patient?
Date of birth	**Social Security Number**	Gender (m/f)	Other Insurance? ☐ Yes ☐ No		Primary care physician (last name, first name, M.I.)	☐ Yes ☐ No

Acknowledgement: The information supplied on this form is true and complete. I assign benefits to Neighborhood Health Plan (NHP) for the cost of services when the liability for payment is the responsibility of another plan/HMO, worker's compensation plan or other coverage. I (we) agree that NHP and its affiliated Health Care Providers, may obtain or release my (our) medical information including medical records, medical coverage available or other medical data for the purposes of administering benefits, evaluating medical care provided, conducting quality assurance reviews and analysis, conducting medical research, and/or as required by law. I (we) understand that for NHP coverage to be in effect when medical care supplies are obtained, all care and supplies must be authorized and provided by participating care physicians (as listed above).

Acuerdo: La información proporcionada en esta forma es veraz y completa. Asigno (asignmos) beneficios a NHP por el costo de servicios cuando la responsabilidad del pago sea de otro plan de salud/HMO, plan de compensación para trabajadores o otro tipo de cobertura. Estoy (estamos) de acuerdo que NHP y sus Proveedores de Cuidado de Salud afiliados puenden obtener o divulger mi (nuestra) información médica, incluyendo registros medicos, cobertura médica disponible o otra información médica, con el próposito de administrar beneficios, evaluar la atención médica proporcionada, realizar revisiones y análisis de control de calidad, realizar investigaciones médica y/o cuando es requerida por la ley. Yo entiendo (entendemos) que para que la cobertura de NHP tenga vigencia para la obtención de suministros médicos, toda la atención y todos los sumistros deben ser autorizados y proporcionados por un medico de cuidado primario paricipante autorizado (segun se indica arriba).

All information must be completed and form signed before processing can begin

Employee's signature: ______________________ Date: ________

Employer contact name (please print): ______________ Phone: __________ Employer's signature: ______________________ Date: ________

Return white original to Neighborhood Health Plan — Yellow copy to employer — Pink copy to employee