

**PCP SELECTION FORM**  
PLEASE PRINT

**STATE OF LOUISIANA**

Completion of this form does not guarantee enrollment.

You must also complete the Scantron form and return both forms to your personnel/payroll department.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M/F Social Security # \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 Primary Care Physician Selection \_\_\_\_\_

Only if enrolling for dependent coverage, list spouse first then each dependent separately, oldest first. If enrolling more than 6 dependents, use a second form.

	FAMILY DEPENDENTS			Date of Birth Mo. Day Year	Social Security Number (Needed for Enrollment)	Sex Circle One	Primary Care Physician Last Name, First Name, MI	Existing Patient
	Last	First	Middle					
Spouse						M / F		Yes Nd
Dependent						M / F		Yes Nd
Dependent						M / F		Yes Nd
Dependent						M / F		Yes Nd
Dependent						M / F		Yes Nd
Dependent						M / F		Yes Nd

Are you or family members listed above covered by any other health Insurance/HMO from another employer/organization/Medicaid?  No  Yes If Yes provide the following:

Policy Holder's Name	Social Security No.	Birthdate	Policy Number	Group Number	Coverage Type	Eff. Date
Employer/Company	Insurance Company/HMO (Name/Address/Phone)			Persons covered under other policy		

Please return this form to your personnel/payroll department or mail to:  
 Humana Enrollment  
 P.O. Box 14330  
 Lexington, KY 40512-4330

Any questions, please call Member Services  
 1-800-564-9159  
 Louisiana Relay Service TDD Assistance: 1-800-846-5277