Blue Cross & Blue Shield of Rhode Island (BCBSRI)
Primary Care Physician Selection Form

As a member of BlueCHiP Coordinated Health Plan, BlueCHiP for Medicare, or BlueCHiP for RIte Care, you must choose one of our network providers to be your primary care physician (PCP). Your PCP will provide or arrange for most or all of your covered services, and you must receive all routine care from plan providers, except in emergency care situations or for out-of-area urgent care/renal dialysis. BlueCHiP for Medicare Preferred Plan members please refer to your Evidence of Coverage for additional out-of-network benefits.

Please complete this form and return it to: Blue Cross & Blue Shield of Rhode Island, Attn: Customer Service, 444 Westminster St., Providence, RI 02903. If you have any questions, please contact the Customer Service Department at one of the numbers listed below:

BlueCHiP for Medicare……..……..…....(401) 277-2958 or 1-800-267-0439
TTY/TDD (Telecommunications Device for the Deaf)……...(401) 831-2202 or 1-877-232-8432

BlueCHiP Coordinated Health Plan/BlueCHiP for RIte Care…..(401) 274-3500 or 1-800-564-0888
TTY/TDD (Telecommunications Device for the Deaf)……1-888-252-5051

Customer Service hours are Monday through Friday from 8:00 a.m. to 8:00 p.m., and Saturday from 8:00 a.m. to 2:00 p.m.

Providers may contact the Physician and Provider Service Center at (401) 274-4848 or 1-800-230-9050, or fax this form to Customer Service at (401) 459-5089 or (401) 459-2006.

Member name *(please print)*:_____
Member ID number *(located on your BCBSRI ID Card)*:_____
Member signature:_____
Name of PCP selected:_____

Please select an <u>individual</u> physician, not a group practice. See your Provider Directory for specific PCP specialties.

PCP National Provider Identifier (NPI):_____ Effective date of change:_____
(Listed in the Provider Directory)

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PROVIDER DIRECTORY REQUEST FORM

PLEASE CHECK ☑ ONE: ☐ BlueCHiP for Medicare ☐ BlueCHiP Coordinated Health Plan
☐ BlueCHiP for RIte Care

NAME:_____ MEMBER ID#:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____
PHONE: (_____) _____

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