

# Community Care of North Carolina/Carolina ACCESS Enrollment Form for Medicaid Recipients

This form must be completed by a staff member with your practice on behalf of the recipient.

**PRACTICE INFORMATION:**

Date: \_\_\_\_\_ County: \_\_\_\_\_

Staff completing form: \_\_\_\_\_

Name of Practice: \_\_\_\_\_

Carolina ACCESS Medicaid ID Enrollment Number: \_\_\_\_\_

**PATIENT INFORMATION:**

Head of Household: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

\_\_\_\_\_

City State Zip Code

Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_ Email: \_\_\_\_\_

Person to be Enrolled	Date of Birth	MID

- Transportation to doctor needed     Referred for county transportation
- Handbook provided at time of interview     Handbook mailed to head of household

SIGNATURE OF PATIENT OR HEAD OF HOUSEHOLD IF PATIENT IS A MINOR:

DATE: \_\_\_\_\_

***(By signing, I certify that I have received an explanation of the benefits of Carolina ACCESS and my freedom to choose a participating provider)***

**Mail or fax the completed form to the department of social services in the county in which  
the recipient resides**

Division of Medical Assistance  
Community Care of North Carolina/Access Care