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: _____

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

Group Administrator Phone Number: _____

**Check Appropriate Column**

| NAME | SOCIAL SECURITY NUMBER | ADD | DELETE | CHANGE | EFFECTIVE DATE | REMARKS | FOR INTERNAL USE ONLY IACS NUMBER |
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Please return this form to:

CareFirst BlueCross BlueShield/CareFirst BlueChoice, Inc.
Enrollment & Billing
10453 Mill Run Circle
Owings Mills, MD 21117
Mail Stop 02-330



CUT5796-1S (1/02)