

Primary Care Physician Election Form

HMO Blue® Texas
 P.O. Box 660044
 Dallas, Texas 75266-0044
 Customer Service: 1-888-322-2379

Please complete this form and mail it directly to HMO Blue Texas Customer Service at the above address.

If enrolling in HMO Blue Texas for the first time, list the Primary Care Physician (PCP) of your choice in the proper space below. You may select a different PCP for each covered family member, or you may select the same one for the entire family. If you wish to change your PCP, please call our Customer Service Department.

Group # 71779 Employer Name The University of Texas System

Name of Employee's UT System Institution _____

Work Phone Number _____ Home Phone Number _____

Subscriber Number: - -

Please select a Primary Care Physician below for yourself and for each covered family member.

Person	Relationship	Last Name	First Name	M.I.	Date of Birth			Sex	Primary Care Physician Selection			
					mo	day	yr		M/F	Last Name,	First Name	PCP Number
Subscriber	Self											
Spouse												
Dependent												
Dependent												
Dependent												
Dependent												

I authorize any physician, hospital or other health care provider to disclose to HMO Blue Texas all medical information relating to individuals named on this application, if permitted by law.

Subscriber's Signature _____ Date _____



BlueCross BlueShield
of Texas

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