Southland IPA

Primary Care Physician (PCP) Selection Form

HMO MEMBERS ONLY

SUBSCRIBER INFORMATION

(Please Print)

Date:______________________ Primary Care Physician (PCP):____

Name:____

Date of Birth:____________________ Age:__________________ Sex: ☐ M ☐ F

Address:____ Apt #:___________________

City:___________________________ State:__________________ Zip:_____________________

Telephone (Day): (_______) _____________________ Telephone (Evening): (_________) __________________
Area Code Area Code

HMO Subscriber Number:_______________________ Employer Group ID Number:______________________

HMO Coverage Effective Date:___________________

DEPENDENTS

Name:___________________________________ Date of Birth___________ Sex ☐ M ☐ F PCP:_________________________

Name:___________________________________ Date of Birth___________ Sex ☐ M ☐ F PCP:_________________________

Name:___________________________________ Date of Birth___________ Sex ☐ M ☐ F PCP:_________________________

Name:___________________________________ Date of Birth___________ Sex ☐ M ☐ F PCP:_________________________

Name:___________________________________ Date of Birth___________ Sex ☐ M ☐ F PCP:_________________________

Name:___________________________________ Date of Birth___________ Sex ☐ M ☐ F PCP:_________________________

Subscriber's Signature:___________________________________ Date:________________________

Send Completed Registration to: Southland IPA, P.O. Box 728, Frankfort, IL 60423