Carolina CA ACCESS

Provider Name: _____

Date: _____

I have chosen the above practice as the Carolina ACCESS provider for the individuals listed below. I have chosen this provider of my own free will and understand that all of the health care needs for the people listed below must be delivered or referred by the Carolina ACCESS provider I have chosen. I also understand that I should contact this office before receiving health care at any other doctor's office.

Printed Name:_____ Phone: _____

Signature:_____ Date: _____

Recipient Name	Date of Birth	Medicaid ID Number