REPLY REQUESTED

Dear Member:

Welcome to Health Plus Physicians Organization (HPPO). Please let us know which Primary Care Physician you have selected.

Blue Cross Blue Shield of Illinois, HMO Illinois, and Blue Advantage members please note the following:

Health Plus Physicians Organization is aware that you have indicated your Primary Care Physician choice on your application for your Blue Cross Blue Shield of Illinois plans. However, Blue Cross Blue Shield of Illinois does not inform the administrative site office of your Primary Care Physician selection.

In addition to your primary care physician information HPPO also needs to be informed if you or your covered family members have other insurance including Medicare.

For your convenience, we have included a HPPO Physician Directory to help you choose your primary care physician. Please be aware that some physicians will not schedule appointments unless they have been assigned to you.

Please fill out the form below completely and mail it to:

Health Plus Physicians Organization
Woodfield Corporate Center
475 North Martingale Rd. Suite 340
Schaumburg, IL 60173

Or fax the completed form to: **847-619-6693**

If you have any questions, please feel free to speak to a customer service representative at 847-619-6671
Representatives are available Monday thru Friday 5:30 a.m. – 3:30 p.m.

It is imperative that HPPO knows your primary care physician selection.

Insured Name: _____ Identification Number: _____

Primary Care Physician: _____

Spouse's Name: _____ Primary Care Physician: _____

Dependent's Name: _____ Primary Care Physician: _____

Dependent's Name: _____ Primary Care Physician: _____

If your family has other insurance, please complete the bottom portion.

Covered Persons Name: _____ Identification Number: _____

Insurance Company Name: _____Phone Number: _____

Effective Date: _____ Cancellation Date: _____

Persons Covered: _____

If you are 65 or older:
Are you currently employed? Yes: ☐ No: ☐
Are you a full time employee? Yes: ☐ No: ☐
Are you covered by Medicare? Yes: ☐ No: ☐
Is your spouse covered by Medicare? Yes: ☐ No: ☐

I acknowledge that the above statements are true and correct.

Date: