Comprehensive Care Partnership (CCP)
Enrollment Form
New River Health Center

Policyholder Name: _____ Address: _____

PEIA ID Number: _____ _____

Daytime Phone: _____ Email: _____

Covered Individuals	Date of Birth	Relationship to Policyholder (Self, Spouse, Child)	CCP Location Include Name of Facility and Provider ID Number
			Facility: _____ CCP Provider ID #: _____
			Facility: _____ CCP Provider ID #: _____
			Facility: _____ CCP Provider ID #: _____
			Facility: _____ CCP Provider ID #: _____
			Facility: _____ CCP Provider ID #: _____

I agree that the above-listed persons carried on my PEIA PPB Plan coverage will participate in the CCP program at the above-listed health care provider. I agree the above-listed person(s) will abide by the rules, policies and restrictions of the CCP program.

Policyholder signature: _____ Date: _____

Please return this form to: **WV PEIA, Attn: CCP, State Capitol Complex, 1900 Kanawha Blvd East, Charleston, WV 25305-0710.** Coverage in the CCP will be effective on the first day of the month following the month we receive your enrollment form, if received before the 25th of the month.