DC HealthCare Alliance Plan Transfer Form

Questions, call the HELPLINE, (202) 639-4030
Hearing Impaired TDD/TTY (202) 639-4041

Si usted desea, puede procurrar a alguien que habile espanol al (202) 639-4030

**This form should only be used to change the health plan for you or your family. You can change by mail, and send back in the envelope provided. Or call the HELPLINE at (202) 639-4030 and change over the phone.

STEP 1: Head of Household Information

First Name	Middle Initial	**Last Name**	Telephone Number
Home Address	Apt #	City	State / Zip
Birthdate	Alliance Number	Social Security Number (optional)	
Name of Health Plan you choose		Name of personal doctor you want	

STEP 2: Information on other members of household

First Name	Middle Initial	**Last Name**
Birthdate	Alliance Number	Social Security Number (optional)
Name of Health Plan you choose		Name of personal doctor you want
First Name	Middle Initial	**Last Name**
Birthdate	Alliance Number	Social Security Number (optional)
Name of Health Plan you choose		Name of personal doctor you want
First Name	Middle Initial	**Last Name**
Birthdate	Alliance Number	Social Security Number
Name of Health Plan you choose		Name of personal doctor you want
First Name	Middle Initial	**Last Name**
Birthdate	Alliance Number	Social Security Number (optional)
Name of Health Plan you choose		Name of personal doctor you want

If you need more space for names, write on the back of this form. Thank you.

Head of Household Signature:___________________________________ ***Date***:_________________

STEP 3: Fill out the Personal Health Risk Assessment Form printed on yellow paper.

Return forms in the envelope provided – no stamp needed.
Or call the HELPLINE at (202) 639-4030 to change over the phone.