PROVIDER SEARCH INSTRUCTIONS

CalCPA Health Anthem

anthem.com/ca

Use the online Find Care tool to look for doctors, hospitals, labs, and other health care providers in your Anthem Blue Cross plan. Check if your favorite doctor is part of your plan, or look for one near you. Avoid getting care from doctors outside of your plan if you can — it will cost you more or your plan may not cover it all.

All CalCPA Health medical plans utilize the Anthem Blue Cross network of providers.

Follow the steps below to find an in-network provider.

1. Visit anthem.com/ca and go to "Find Care".
2. If using "Search as a Member", simply log in with the profile you created and search for a provider – the network you belong to will be pre-selected.
3. If using "Search as Guest", you must select one of the following networks.
4. For PPO/HSA plans in California, choose Blue Cross PPO (Prudent Buyer) – Large Group.
5. For Select PPO/HSA plans in California, choose Select PPO.
6. For PPO/HSA/Select PPO/Select PPO HSA plans outside of California, choose National PPO (BlueCardPPO).
7. For HMO plans, choose Blue Cross HMO (CACare) – Large Group.
8. For Select HMO plans, choose Select HMO.

Select a doctor to see more information, such as:

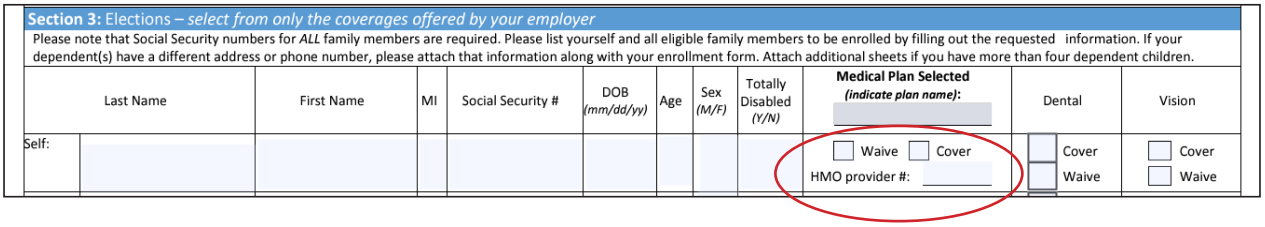
Training • Specialties • Languages spoken • Address (including a map) • Phone number

Employee Enrollment Application

When completing the Employee Enrollment Application (seen below), if you are choosing your Primary Care Physician (PCP), you must provide their PCP ID.

If the medical group is an Independent Physician Association (IPA), you will need to provide the 6-digit code found in the provider search (i.e. in ABC123, "ABC" identifies the medical group and "123" identifies the physician).

If the medical group is a Primary Medical Group (PMG), you must provide the 3-digit code found in the provider search (i.e. A1C) which identifies the medical group.



Section 3: Elections – *select from only the coverages offered by your employer*

Please note that Social Security numbers for *ALL* family members are required. Please list yourself and all eligible family members to be enrolled by filling out the requested information. If your dependent(s) have a different address or phone number, please attach that information along with your enrollment form. Attach additional sheets if you have more than four dependent children.

	Last Name	First Name	MI	Social Security #	DOB *(mm/dd/yy)*	Age	Sex *(M/F)*	Totally Disabled *(Y/N)*	**Medical Plan Selected** ***(indicate plan name):***	Dental	Vision
Self:									☐ Waive ☐ Cover HMO provider #:	☐ Cover ☐ Waive	☐ Cover ☐ Waive

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