



Wake County Medical Society

2500 Blue Ridge Road, Suite 312

Raleigh, NC 27607

(919) 783-0404; x-22 or x-21

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# PHYSICIAN ACCEPTANCE FORM

COUNTY \_\_\_\_\_ Must Be a Wake County Resident

Patient Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone # \_\_\_\_\_ Social Security # (If none, state none) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Spanish Materials Required

Enrolled by: \_\_\_\_\_  
Print Name (Participating Physician)

Practice Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Person completing this form \_\_\_\_\_ Phone/extension \_\_\_\_\_

PATIENT was referred to your practice by: \_\_\_\_\_  
Name of doctor Name of Practice (or Hospital)

If patient is approved, indicate the effective date for enrollment: \_\_\_\_\_

Is there any reason why this patient should not establish primary care with one of the Project Access Enrollment Site Clinics? Yes  No  If yes, reason: \_\_\_\_\_

I understand that the Project Access office will screen the above-referenced patient. Pending eligibility, I hereby accept this individual as a Project Access Participant.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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## PROJECT ACCESS ELIGIBILITY REQUIREMENTS

1. Must be a Wake County Resident and provide proper identification.
2. Income above 185% of the Federal poverty guideline.
3. Does not have any health insurance, Medicare or Medicaid.