



Membership Inquiry Form

**Please fax this form to: 646-786-1838 or
Mail to Amida Care, Inc. 248 W. 35th St New York, NY 10001**

Please complete the following information.

First Name _____ Last Name _____

CIN # _____ DOB _____

Street and Number _____

Apartment/Floor _____

City _____, NY ZIP _____

Telephone number (home) _____

Cell phone: _____

Alternate phone: _____

Best time to contact me is: _____

I agree that a VidaCare representative may contact me as follows

❖ By Phone at the numbers noted above

Message may be left on answering machine: **Yes** **No**

Message may be left with another individual who answers the telephone: **Yes** **No**

NOTE: VidaCare representative will not mention VidaCare in the message, but will identify themselves by name and say they are with a health plan.

❖ By Mail at the address noted above

NOTE: VidaCare is not listed on the return address on envelope

Signature

Date