Member Primary Care Provider (PCP) Change Request Form

Please complete this form with your provider if you want to change your PCP. Your provider will then send this form to your health plan, letting them know about the change.

Your PCP is the provider you go to first and most often for your healthcare needs and for guidance about important preventive care to keep you healthy and active. Please print clearly and complete all fields. Be sure to sign the bottom of the form. You can also choose a new PCP by calling the Member Services phone number on the back of your Member ID card.

Member First Name: _____ Member Last Name: _____

Date of Birth: _____ Member Phone Number: _____

Member ID #: _____

Current Primary Care Provider (PCP) Name: _____

Group/Location: _____

New Primary Care Provider (PCP) Name: _____

Group/Location: _____

Address: _____

PCP Plan Provider #: _____ Effective Date of Change: _____

Reason for Change: _____

_____

Member Signature _____ Date: _____

Preparer name: _____ Preparer Phone Number: _____

Preparer signature: _____ Date: _____

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Instructions

Please fax this form to [1-855-247-7480].

All PCP changes submitted prior to the [10th] of the month will be effective on the first of the same month, all PCP changes submitted after the [10th] of the month will be effective the first of the following month.

Upon receipt of form, turnaround times can take up to [5] business days to process. However, the member's new PCP may begin to see them effective immediately.

Please contact your plan for details.