



PCP Change Request Form

Member Information

First name	Middle initial	Last name
Date of birth	Member ID number	Social Security Number
Address	Telephone number	
City	State	ZIP code

PCP Change Request

Requested PCP name	NPI number	
Office address		
City	State	ZIP code
Office telephone number	Tax ID number	Effective date

Reason for Change from Assigned PCP

Please check appropriate response below:

<input type="checkbox"/> New member made first time selection	<input type="checkbox"/> Provider location
<input type="checkbox"/> Already patient with requested PCP	<input type="checkbox"/> Association with hospital or medical group
<input type="checkbox"/> Requested PCP sees family members	<input type="checkbox"/> Language / communication barriers
<input type="checkbox"/> Member preference	<input type="checkbox"/> Wait time in provider office
<input type="checkbox"/> Member moved	<input type="checkbox"/> Appointment availability / access to care
<input type="checkbox"/> PCP hours did not fit member needs	<input type="checkbox"/> Established relationship with another PCP
<input type="checkbox"/> Quality of care	<input type="checkbox"/> Other

Signature of member or authorized representative	Date
Print name of member or authorized representative	

Directions: Please fax this form, with a copy of the member ID card, if available, to member Services Department at **1-866-361-8495**. If you have questions about this form or want to make this request over the telephone, please call Member Services at [1-866-827-2710](tel:1-866-827-2710) (TTY users dial [711](tel:711)).

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