

# SoonerSelect PCP Change Request Form

Use this form for Aetna Better Health® of Oklahoma, Oklahoma Complete Health, and Humana Healthy Horizons.

|                                                                                                              |                                            |                              |  |  |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------|------------------------------|--|--|
| <b>Member Information</b>                                                                                    |                                            |                              |  |  |
| Member Name:                                                                                                 | DOB:                                       | Member ID #:                 |  |  |
| Phone:                                                                                                       | Address:                                   |                              |  |  |
| City:                                                                                                        | State:                                     | ZIP:                         |  |  |
| <b>Current Primary Care Provider (PCP)</b>                                                                   |                                            |                              |  |  |
| Current PCP:                                                                                                 | Clinic:                                    |                              |  |  |
| <b>Requested Primary Care Provider (PCP)</b>                                                                 |                                            |                              |  |  |
| Requested PCP:                                                                                               | Clinic:                                    |                              |  |  |
| Effective Date Requested:                                                                                    |                                            |                              |  |  |
| <b>Reason for PCP Change</b>                                                                                 |                                            |                              |  |  |
| New patient<br>Moved                                                                                         | Provider unavailable<br>Patient preference | Continuity of care<br>Other: |  |  |
| <b>Member Authorization</b>                                                                                  |                                            |                              |  |  |
| I authorize my SoonerSelect Managed Care Organization to change my Primary Care Provider as requested above. |                                            |                              |  |  |
| Member Signature:                                                                                            |                                            | Date:                        |  |  |
| <b>Clinic/Provider Completing Form</b>                                                                       |                                            |                              |  |  |
| Clinic Name:                                                                                                 | Prepared By:                               |                              |  |  |
| Phone:                                                                                                       | Fax:                                       |                              |  |  |
| Provider/Authorized Representative Signature:                                                                |                                            | Date:                        |  |  |

## Submission instructions

| MCO                             | Fax            | Email                                | Other                                                           |
|---------------------------------|----------------|--------------------------------------|-----------------------------------------------------------------|
| Aetna Better Health of Oklahoma | 1-833-542-0467 | MemberServices-ABHOklahoma@AETNA.com | Include member ID copy if available.<br>Support: 1-844-365-4385 |
| Oklahoma Complete Health        | 1-833-611-2153 | OKPCPChange@centene.com              |                                                                 |
| Humana Healthy Horizons         | N/A            | OK_PCP_Change@humana.com             |                                                                 |

## Submission Checklist

Member demographics complete  
Correct Member ID entered  
Requested PCP identified  
Reason for change documented  
Member signature obtained  
Provider signature completed  
Submitted to correct MCO

