HIGHMARK WESTERN NEW YORK

PO BOX 4208 - Buffalo, New York 14240-4208

Primary Care Physician (PCP) Change Form

This form ***will not be processed*** if the signature of the member or his/her parent or guardian is not provided below.

Today's Date: _____

To Be Completed by the Member

Member ID: _____

Group #: _____

Member name: _____
(Please print)

Parent/Guardian name: _____
(if applicable) ***(Please print)***

New PCP name: _____
(Please print)

NEW PRACTICE NAME AND ADDRESS (below):

PCP change effective date: ☐ Today ☐ First day of the upcoming month
(check one box)

Member or Parent/Guardian signature: _____
(Signature required)

Fax completed form to Member Service at:

Individual Market and Medicare Advantage Members: 1-888-333-4316

Commercial/ASO Group Members: 1-833-841-8070

Medicaid Managed Care and CHPlus Members: 1-866-840-4993