
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 number: _____

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/Medicare Advantage/Commercial Members: 1-888-333-4316
Commercial ASO Members: 1-833-841-8070