Primary Care Physician (PCP) Change Request

This is a request to change my Primary Care Physician (PCP). The new PCP will be:

Dr. _____ _____
(Last & First name) (Provider's phone number)

Dr. Address:_____

I _____ verify that this is my request.
(Member name)

Office Staff/Witness Signature _____

Date of Service: _____

Member ID #: _____

Member Address: _____

_____

Member Date of Birth: _____

Member Contact Phone Number: _____
*(Parent/Guardian if minor, Power of Attorney)

Member Signature: _____
***** (Parent/Guardian if minor, Power of Attorney)

Date: _____

* Note – Member Services must have appropriate documentation of guardianship or Power of Attorney on file. If not, the change of PCP will NOT be made.

Member PCP changes should be faxed to Member Services **within 24 hours of members' date of service** in order for the change to be acknowledged.

Please fax requests to: **602-778-1814**.

If you have any questions please contact member services at: **602-778-1800 or 1-866-560-4042**.