



# PCP Change Request Form

Request for a change of primary care provider (PCP) with Missouri Medicaid Managed Care

## Part 1 - Member Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Member date of birth: \_\_\_\_\_ Member Identification # (Health Plan ID or DCN): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Member home phone number: \_\_\_\_\_ Member cell phone number: \_\_\_\_\_

Member e-mail address: \_\_\_\_\_ Guardian or Parent (if applicable): \_\_\_\_\_

## Part 2 - Reason for PCP Change Request:

Reason for change (check one):

- Unhappy with PCP
- Quality of Care
- Appointment Availability
- Patient is already established
- PCP retired
- PCP left location
- PCP is deceased
- PCP office/hours inconvenient
- Member/PCP moved out of service area
- Other (please explain):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Part 3 - PCP Change Request:**

\_\_\_\_\_  
New PCP name: \_\_\_\_\_ New PCP NPI: \_\_\_\_\_

\_\_\_\_\_  
New PCP address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

\_\_\_\_\_  
Fax number: \_\_\_\_\_ Phone number: \_\_\_\_\_ Effective Date of Change: \_\_\_\_\_

\_\_\_\_\_  
Member, parent or guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax this completed form to the member's health plan:

Healthy Blue: **833-391-8652**

Home State: **866-390-4429**

United Healthcare: **844-386-9286**

**Note: Effective date of change, member signature and signature date required.**