

Primary Care Physician

ONE MEMBER PER FORM



home state health™

Member Information

First Name:

MI:

Last Name:

MO HealthNet ID*:

Date of Birth (mmddyyyy):

SSN:

Telephone number: - -

Mailing Address:

City:

State:

Zip Code:

PCP Change Request - Please provide PCP Information

Requested PCP Name PCP#

Office Address:

City:

State:

Zip Code:

Office Phone: - - Effective Date (mmddyyyy):

PCP change will be in effect within 2 business days of the request.

Reason for Change from Assigned PCP - Choose all that apply. Select at least one.

- | | |
|--|--|
| <input type="radio"/> New Member - made 1st time selection | <input type="radio"/> Provider Location |
| <input type="radio"/> Already patient with requested PCP | <input type="radio"/> Association with hospital or medical group |
| <input type="radio"/> Requested PCP already sees family member | <input type="radio"/> Language/communication barriers |
| <input type="radio"/> Member Preference | <input type="radio"/> Wait time in provider office |
| <input type="radio"/> Member Moved | <input type="radio"/> Availability to get appointment/access to care |
| <input type="radio"/> PCP Hours didn't fit Member need | <input type="radio"/> Established relationship w/ another PCP |
| <input type="radio"/> Quality of Care | <input type="radio"/> Other |

Signature of Member or Authorized Representative

Date (mmddyyyy)

Print Name of Member or Authorized Representative

Directions: Please **FAX** Member Change Data forms, with a copy of the Member ID card, if available, to Home State Health Member Services Department at **1-866-390-4429** or mail it to Home State Health Member Services, 11720 Borman Drive, St. Louis, MO 63146. If you have questions about how to complete this form or want to make this request over the phone, please call the Home State Health Member Services Department, from 8 a.m. to 5 p.m., Monday through Friday, at 1-855-694-4663 (TTY/TTD: 1-877-250-6113).