**All MCP Primary Care Provider (PCP) Selection/Change Form**

Please complete this form if the Primary Care Provider (PCP) on your Healthcare ID card is incorrect.

Please fax completed form to the MCP # listed below.

**New Provider Information** (please print)

|  |  |  |  |
| --- | --- | --- | --- |
| **PCP Name** |  | **Clinic** |  |
| **PCP NPI** |  | **Tax ID** |  |
| **PCP Address** |  | **City** |  |
| **State** |  | **Zip Code** |  |
| **PCP Phone #** |  | **PCP Fax #** |  |
| **Effective. Date** | **/ /** |  |  |
| **Have you seen this provider in the last year?** 🞏 Yes 🞏 No (Please check one) | | | |

**Change Reason (**Please check one)🞏 No reason – I just want different doctor on my card 🞏 More convenient location/hours 🞏 Referral by family/friend 🞏 I am an existing patient with this doctor 🞏 Dissatisfaction

🞏 I requested this PCP when I was enrolled, but was assigned a different doctor

**Member Information** (please print)

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Date of Birth** | **/ /** | **Phone #** | **( ) -** |
| **Age** |  | **Medicaid ID #** |  |
| **Member ID #** |  | **Phone #** |  |
| **Address** |  | **City** |  |
| **State** |  | **Zip Code** |  |
| *(A new ID card will be sent out to this address within seven to ten business days.)* | | | |

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**Signature of Member or Member’s Guardian** **Today’s Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider (Staff) Signature Today’s Date**

**Managed Medicaid Care Plan (MCP) Information**

· CareSource; Fax Number: (937) 226-6916

· Buckeye Health Plan; Fax Number: (866) 719-5435

· Molina Healthcare; Fax Number: (888) 295-4761

· Paramount Advantage; Fax Number: (419) 887-2047

· UnitedHealthcare Community Plan; Fax Number: (844) 386-9286