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.