PCP Change Request Form

If a Molina Healthcare member is requesting to change their primary care provider (PCP), please complete this form and fax it to (888) 656-7582. Please complete all fields.

Member Information

Member Name _____ Member ID# _____

Member Phone Number _____ Member DOB _____

Member Address _____

City _____ State _____ ZIP code _____

Print Name of Authorized/Responsible Party _____

Signature of Member or Authorized/Responsible Party _____

(Signature required to complete process)

Date _____

We will mail a new ID card to the address on file. If you've recently moved, please contact AHCCCS at 1(855) HEA-PLUS (1-855-432-7587).

Current PCP Information

Current PCP Name _____

Reason for change (Please check one):

- ☐ Moved to new service area
- ☐ PCP not accepting new patients
- ☐ PCP relocated
- ☐ PCP deceased
- ☐ PCP retired
- ☐ Other _____

New PCP Information

Provider Name _____ NPI _____

Practice Address _____ Tax ID _____

City _____ State _____ ZIP code _____

Office Contact Name _____ Phone _____

Office Contact Signature _____ Date _____

If you have any questions, please call Molina Healthcare Member Services at (800) 424-5891 (TTY/TTD: 711).

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