Member PCP Change Request Form

Please complete one form per member or household. PCP changes will require 48 hours to complete. The effective date will be backdated to the date the PCP Change Request Form was received. **Incomplete forms will not be processed**. Please contact Provider Services at **1-800-578-0775** if you have any questions regarding this form.

**denotes required fields.*

Member Information

*First Name: ______________________ *Last Name: ______________________

*Passport ID (or Kentucky Medicaid ID): ______________________ *DOB: ______________________

Provider Information

*Requested Provider Name: ______________________

*Requested Provider Group Name: ______________________

*Requested Provider TIN: ______________________ *Group NPI: ______________________

*Provider Servicing Location Address: ______________________

*Contact Name: ______________________ *Contact Phone Number: ______________________

Additional PCP Change Requests

Member Name: ______________________ Member DOB: ____/____/______ Member Passport ID: ______________
(or Kentucky Medicaid ID)

Member Name: ______________________ Member DOB: ____/____/______ Member Passport ID: ______________
(or Kentucky Medicaid ID)

Member Name: ______________________ Member DOB: ____/____/______ Member Passport ID: ______________
(or Kentucky Medicaid ID)

Member Name: ______________________ Member DOB: ____/____/______ Member Passport ID: ______________
(or Kentucky Medicaid ID)

Member Name: ______________________ Member DOB: ____/____/______ Member Passport ID: ______________
(or Kentucky Medicaid ID)

***Reason for PCP Change Request** Please check one of the following:

- ☐ Already a patient with requested provider
- ☐ Prefer a different primary care provider
- ☐ Dissatisfaction with current primary care provider
- ☐ Convenient location/office hours
- ☐ Other: ______________________

*Member or Parent/Guardian Signature: ______________________ *Date: ______________

*Relation to member: ______________________

*Provider Signature: ______________________ *Date: ______________

Please submit this form to Provider Services. **Fax: 1-844-834-2155**

Internal Use ONLY:	Rec'd Date	Rec'd By	Ticket #	Completion Date

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