**Request to Change Primary Care Provider (PCP)**



Check appropriate line of business: ☐Medicaid

Fields with an asterisk (\*) are required and must be completed

MEMBER INFORMATION:

\*Member’s Name: \*Molina ID#:

Please print FIRST and LAST name

\*Date of Birth: \*Phone #:

\*Mailing Address:

\*City: \*State: \*Zip Code:

PROVIDER INFORMATION: Please provide PCP information

\*Requested full PCP Name:

\*Office Phone #:

\*Office Address:

\*City: \*State: \*Zip Code: Effective Date of Change (MMDDYYYY):

The effective date will be based on the Plan’s selection/change policy

\*Reason for Change—Check all that apply:

☐New Member—1st time selection ☐Provider Location

☐Already established with requested PCP ☐Association with hospital or Medical group

☐Requested PCP sees a family member ☐Language/communication barrier

☐Member Preference ☐Wait time in providers office

☐Member Moved ☐Quality of Care

☐Availability to get appointment/Access to care ☐Provider Request to disenroll

☐Provider left Network ☐Other:

\*Signature of Member or Authorized Representative

\*Date:

Directions: Fax the completed form to (844) 834-2155. If you have questions about completing the form, please call the Member Services number on the back of the ID card.

27625LTRMDNVEN

220112