Amerigroup RealSolutions in healthcare

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Request for a Change of Primary Care Provider (PCP)

Member Name: _____ Member ID: _____

Member Address: _____

Member City: _____ State: _____ ZIP code: _____

Current PCP Name: _____

Reason for change (please check one):

- ☐ Member moved out of service area
- ☐ PCP retired
- ☐ PCP left location
- ☐ PCP moved out of service area
- ☐ PCP deceased (died)
- ☐ Other (please explain) _____

New PCP Name: _____

New PCP Address: _____

New PCP City: _____ State: _____ ZIP code: _____

Please fax this completed form to 757-233-9903, Attn: Provider Relations, or mail it to:

Contracting and Provider Relations
Amerigroup Washington
705 Fifth Avenue South, Suite 300
Seattle, WA 98104

Member Signature: _____ Date: _____

Member Phone Numbers: (_____) _____ (_____) _____

Office Use Only

Clinic Staff Name and Phone Number: _____ (_____) _____