coordinatedcare™

PCP Selection and Change Form

Member Information - This form is also available online. ***Required Field**

First Name: MI: Last Name:

Member ID*: Date of Birth (mmddyyyy):

SSN: Telephone number: – –

Mailing Address:

City: State: Zip Code:

PCP Change Request - Please provide PCP Information

Requested PCP Name NPI#

Office Address:

City: State: Zip Code:

Office Phone: – –

Effective Date (mmddyyyy):

The effective date will be based upon the plan's selection/change policy.

Reason for Change from Assigned PCP - Choose all that apply. Select at least one.

- ○ New Member - made 1st time selection
- ○ Already patient with requested PCP
- ○ Requested PCP already sees family member
- ○ Member Preference
- ○ Member Moved
- ○ PCP Hours didn't fit member need
- ○ Quality of Care
- ○ Provider Location
- ○ Association with hospital or medical group
- ○ Language/communication barriers
- ○ Wait time in provider office
- ○ Availability to get appointment. Access to care
- ○ Established relationship w/another
- ○ Other

_____

Signature of Member or Authorized Representative

Date (mmddyyyy)

_____

Print Name of Member or Authorized Representative

Directions: Please fax Member Change Data forms, with a copy of the member ID card, if available, to Coordinated Care Member Services Department at **(866) 270-8008**, or mail it to Coordinated Care Member Services, 1145 Broadway, Suite 300 Tacoma, WA 98402. If you have questions about how to complete this form or want to make this request over the phone, please call the Coordinated Care Member Services Department, Monday through Friday, 8 a.m. - 5 p.m. (PST), at **(877) 644-4613** (TDD/TTY 1-866-862-9380).