All MCP Primary Care Provider (PCP) Selection/Change Form

Please complete this form if the Primary Care Provider (PCP) on your Healthcare ID card is incorrect.
Please fax completed form to the MCP # listed below.

New Provider Information (please print)

PCP Name		**Clinic**	
PCP NPI		**Tax ID**	
PCP Address		**City**	
State		**Zip Code**	
PCP Phone #		**PCP Fax #**	
Effective. Date	/ /		

Have you seen this provider in the last year? ☐ Yes ☐ No (Please check one)

Change Reason (Please check one) ☐ No reason – I just want different doctor on my card ☐ More convenient location/hours ☐ Referral by family/friend ☐ I am an existing patient with this doctor ☐ Dissatisfaction ☐ I requested this PCP when I was enrolled, but was assigned a different doctor

Member Information (please print)

Full Name			
Date of Birth	/ /	**Phone #**	( ) -
Age		**Medicaid ID #**	
Member ID #		**Phone #**	
Address		**City**	
State		**Zip Code**	

(A new ID card will be sent out to this address within seven to ten business days.)

_____ _____

Signature of Member or Member's Guardian **Today's Date**

_____ _____

Provider (Staff) Signature **Today's Date**

Managed Medicaid Care Plan (MCP) Information

· CareSource; Fax Number: (937) 226-6916
· Buckeye Health Plan; Fax Number: (866) 719-5435
· Molina Healthcare; Fax Number: (888) 295-4761
· Paramount Advantage; Fax Number: (419) 887-2047
· UnitedHealthcare Community Plan; Fax Number: (866) 888-1129