



# PCP Change Request Form

Member Information			
Member ID Number		Member Name	
Address	Street		
	City	State	Zip
Phone Number			
Print Name of Parent or Guardian			Date
Signature of Member, Parent or Guardian (Required)			Date

Other Insurance Information		
Name	Policy Number	Group Number

PCP Information	
Current PCP	
New PCP	
Name of Person Requesting Change	PCP Change Effective Date

UnitedHealthcare Community Plan Use Only	
Completed By	Date
<p>This form must be filled out legibly and completely and signed by the member or a parent/guardian in order to be processed. Use one form per person, even if they're family members.</p> <p>Fax the completed form to <b>866-888-1129</b>.</p>	



**Primary Care Provider (PCP) Selection Form**

**Please complete this form, and mail it to:**

Molina Healthcare of New York, Inc.  
Attention to: Member Enrollment  
5232 Witz Drive  
North Syracuse, NY 13212-6501

Fax: (315) 234-5916

**Please print clearly.**

**Member Name:** \_\_\_\_\_

**Member ID #:** \_\_\_\_\_

**Member Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip:** \_\_\_\_\_

**Phone number: (\_\_\_\_) \_\_\_\_\_**

Please name the Primary Care Provider (PCP) you would prefer to see:

\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

You can also select or change your PCP online:

- 1) Member Portal: <https://member.molinahealthcare.com/>
- 2) Provider Online Directory : <https://providersearch.molinahealthcare.com>

If you have questions, regarding this letter, call Member Services for this information at (800)223-7242 (TTY: 711), Monday – Friday, 8:00 a.m. to 6:00 p.m.

**For Providers:**

Once the member completes the form, please fax it to (315) 234-5916 (Attention: “Member Enrollment”). The member may also email this form at [MHNYEnrollment@molinahealthcare.com](mailto:MHNYEnrollment@molinahealthcare.com)



FIDELIS CARE

# Member - Primary Care Provider (PCP) Change Request Form

Use this form to let us know that you are changing your Primary Care Provider (PCP). **You must complete each section of the form.** Incomplete forms cannot be processed. Members can also change a PCP over the phone by calling 1-888-FIDELIS (1-888-343-3547).

PLEASE PRINT

## 1. Member Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
MM DD YYYY

Fidelis Care Member ID# (first 9 digits)

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Is member a newborn?  Yes  No

## 2. New Primary Care Provider (PCP) Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Practice Name \_\_\_\_\_ Fax Number \_\_\_\_\_

Practice Address \_\_\_\_\_

Provider TIN\*: (9 digits)

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*\*TIN must match the Office Address the member will utilize*

**PCP Change Effective Date:** Typically the 1st of the month when the form is received by Fidelis Care.

## 3. Provider Attestation (PCP)

I (Fidelis Care provider) hereby attest that the above member has granted consent to change their PCP to the aforementioned provider documented in #2 above.

Today's Date

Provider Signature \_\_\_\_\_

MM DD YYYY

## 4. Send us the completed form

Fax the completed form to 718-393-6635.

The following Fidelis Care plans do **not** require PCP assignments: Essential Plan, Fidelis Care at Home (MLTC), Qualified Health Plans, Fidelis Medicare Advantage, and Fidelis Dual Advantage.

**Providers should always verify a member's PCP assignment via Fidelis Care's Provider Access Online at [providers.fideliscare.org](http://providers.fideliscare.org), or by contacting the Provider Call Center at 1-888-FIDELIS (1-888-343-3547).**

# Primary Care Provider Change or Patient Reassignment Request



Complete **Section 1** to change a Primary Care Provider (PCP) or **Section 2** to assign a member to a new PCP.

## Section 1: PCP Change Request (completed by Member)

Member Name	MVP Member ID No.
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Current or Former Provider Name
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New Provider Name	Provider ID No.	Effective Date of Change
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New Provider Street Address	City	State	Zip Code
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Member Signature	Date
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## Section 2: Patient Reassignment Request (completed by Provider)

By completing Section 2, the PCP is requesting that MVP Health Care® contact the member indicated below to begin the process of selecting a new PCP. By law, the PCP must continue to provide medical care for this member for 30 days after notifying MVP that this patient should be removed from the Provider's roster. Please be aware that the Provider will remain the patient's PCP until MVP completes the process of contacting and successfully assigning the member to a new PCP.

MVP Member Name	MVP Member ID No.
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Current Provider Name	Current Provider NPI No.	Provider ID No.	Date
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Current Provider Street Address	City	State	Zip Code
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For PCP changes in Medicaid Managed Care, Child Health Plus, MVP Harmonious Health Care Plan®, and Essential Plans in the New York Mid-Hudson Region, please be advised that many of these providers are capitated and PCP changes do not happen on demand. If changes are made prior to the 10th of the month, the change does not take effect until the following month.

Return this completed form to MVP by fax to one of the following:

- Commercial Members (HMO, EPO, and Exchange Plans) 518-386-7880
- Essential Plans, Child Health Plus, Medicaid, and MVP Harmonious Health Care Plan Members 914-631-1746
- Medicare Advantage Plans Members 585-327-2227