Request Primary Care Physician Change

FAX TO: **888-884-9642**

(Please fill out all fields)

From: ______________

Date: _______________ ATTN: **NY MEDICAID** PCP CHANGES

Please complete all fields below. Incomplete forms may not be processed.

Member name: ____

Member address:____

UnitedHealthcare ID number: ____

Medicaid number: ____

Current PCP on member's card: ____

Change PCP to: (full name) ____

New PCP UnitedHealthcare provider ID or NPI number:_________________________

New PCP medical group/facility name:______________________________________

New PCP medical group/facility tax ID:_____________________________________

First and last name of individual completing this form:__________________________

Phone number or email address of individual completing this form:_________________

UnitedHealthcare Provider Advocate for group/facility (if known):_________________

Member or Legal Guardian Signature: ______________________________________

Effective Date: ____

Date Signed: ____

By signing this form I am giving my health care provider
permission to give this information to
UnitedHealthcare Community Plan

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