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To: PCP Change Request	From:
Fax: (937) 226-6916	Pages: (including cover page)
Phone:	Date:
Re:	CC:

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**Member Information:** (required)

Member Name: \_\_\_\_\_  
Member ID #: \_\_\_\_\_  
Member Phone/Contact #: \_\_\_\_\_

**Please change my Primary Care Provider to:** (required)

- Provider's Name: \_\_\_\_\_
- Tax ID #: \_\_\_\_\_
- Address, City, State and Zip Code: \_\_\_\_\_
- Provider's Phone Number: \_\_\_\_\_

**Member's reason for requesting the change:** (required)

- More convenient location/hours, explain: \_\_\_\_\_
- Referral by family/friends: \_\_\_\_\_
- Dissatisfaction with doctor/staff, explain: \_\_\_\_\_
- Problems scheduling appointments, explain: \_\_\_\_\_
- I requested Dr. \_\_\_\_\_ when I enrolled through Selection Services but CareSource assigned a different doctor on my CareSource ID card.
- Other: \_\_\_\_\_

**Other family members who should also be changed to the same provider,**

Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Member Number: \_\_\_\_\_

**I want to be contacted by a CareSource representative to discuss the change**

The required fields must be completed for the change to be processed by CareSource. Members can continue to be treated by the **requested** participating Primary Care Provider until the change is complete. The member should continue to use their current ID card until the new ID card is received. PCP changes can take from 1-5 weeks to process.

Member/Member Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Provider (staff) Signature: (required) \_\_\_\_\_ Date: \_\_\_\_\_

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