Primary Care Manager Change Request Form

Provider/Facility: _____ **OR Stamp:** _____

Tax ID#: _____ **Phone:** _____

Beneficiary Information:

Beneficiary Name (required)**:** _____

Beneficiary Phone (required)**:** _____ **ID# or DOB:** (required) _____

Other Family Members:

Beneficiary Name: _____ **ID # or DOB:** _____

Beneficiary Name: _____ **ID # or DOB:** _____

Beneficiary Name: _____ **ID # or DOB:** _____

Reason for Change (required):

- ☐ No reason. I just want a different doctor on my card.
- ☐ More convenient location/hours
- ☐ Referral by family/friend
- ☐ I am an existing patient with this doctor. I did not request this doctor when I enrolled with CareSource Military & Veterans (CSMV).
- ☐ I requested this PCM when I enrolled, but CSMV assigned a different doctor on my CSMV ID card.

☐ I want to be contacted by a CSMV representative to discuss the change.

The **required** fields must be complete for the change to be processed. Beneficiaries can continue to be treated by the requested PCM until the change is complete. The beneficiary should continue to use their current ID card until the new ID card is received. All requests will be processed within 3-5 business days of receipt.

Beneficiary/Beneficiary Representative Signature _____ Date: _____

Provider (Staff) Signature _____ Date: _____

Fax requests to CSMV Beneficiary Services at 1-678-217-8700.

CSMV-TRICARE-P-4088633