PDP Change Request Form

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

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

Member Information

Member Name: (required) _____

Member Phone# (required)**:**_____ **Member ID# OR DOB** (required)**:** _____

Other Family Members

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

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

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

Reason for Change (required)

☐ No reason - I just want a different dentist on my card.
☐ More convenient location/hours
☐ Referral by family/friend
☐ I am an existing patient with this dentist. I did not request this dentist when I enrolled with CareSource.
☐ Dissatisfaction – A CareSource representative will contact you upon receipt of request.
☐ I requested this PDP when I enrolled, but CareSource assigned a different dentist on my CareSource ID card.

☐ 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. Members can continue to be treated by the requested PDP until the change is complete.The member 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.

Member/Member Representative Signature:_____ **Date:**_____

Provider (staff) Signature:_____ **Date:**_____

Fax requests to CareSource at 678-217-8700.