



## Primary Care Provider (PCP) Change Request Form

Provider/Facility: \_\_\_\_\_ OR Stamp: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ Phone #: \_\_\_\_\_

---

### Member Information:

Member Name (required): \_\_\_\_\_

Member Phone # (required): \_\_\_\_\_ Member ID # OR Date of Birth (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 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 HAP CareSource™ MI Coordinated Health (HMO D-SNP)
  - ☐ Dissatisfaction – A HAP CareSource MI Coordinated Health representative will contact you upon receipt of request
  - ☐ I requested this PCP when I enrolled, but HAP CareSource MI Coordinated Health assigned a different doctor on my HAP CareSource MI Coordinated Health ID card
- 

- ☐ I want to be contacted by a HAP CareSource MI Coordinated Health 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 PCP 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 three to five business days of receipt.

Member/Member's Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

Provider (Staff) Signature \_\_\_\_\_ Date: \_\_\_\_\_

Fax requests to HAP CareSource MI Coordinated Health Member Services at 1-937-226-6916.