PMP Change Request Form

Provider/Facility:_____
OR Stamp:_____
Tax ID#: _____
Phone: _____

Member Information:
Member name: (required)_____
Member Phone# (required):_____
Hoosier Healthwise ID Number OR DOB (required):-_____

Other Family Members:
Member name: _____ HHW/HIP ID or DOB: _____
Member name: _____ HHW/HIP ID or DOB: _____
Member name: _____ HHW/HIP ID or DOB: _____

Reason for Change (required):

- □ No Reason – I just want 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.
- □ Dissatisfaction – A CareSource representative will contact you upon receipt of request.
- □ I want to be contacted by a CareSource representative to discuss the change.
- □ This is an established patient or family member of an established patient whom I have treated in the past 24 months from today's date.
- □ This is a patient whom I would like to add to my panel.

The required fields must be completed for the change to be processed. Members can continue to be treated by their requested PMP 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 Representative Signature: _____
Date: _____

As a PMP, I agree to add the above Hoosier Healthwise/HIP member to my panel.
Provider (staff) Signature _____
Date: _____

Fax requests to CareSource's Member Services department at 937-226-6916.

IN-P-0405

Date Issued: 7/6/18 Date Approved: 7/5/18