HAP CareSource™

Primary Care Provider (PCP) Change Request Form

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

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

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™
☐ Dissatisfaction - A HAP CareSource representative will contact you upon receipt of request
☐ I requested this PCP when I enrolled, but HAP CareSource assigned a different doctor on my HAP CareSource ID card

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☐ I want to be contacted by a HAP 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 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 Member Services at 937-226-6916.