

All MCP Primary Care Provider (PCP) Selection/Change Form

Please complete this form if the Primary Care Provider (PCP) on your Healthcare ID card is incorrect.
Please fax completed form to the MCP # listed below.

New Provider Information (please print)

PCP Name	_____	Clinic	_____
PCP NPI	_____	Tax ID	_____
PCP Address	_____	City	_____
State	_____	Zip Code	_____
PCP Phone #	_____	PCP Fax #	_____
Effective. Date	____/____/____		

Have you seen this provider in the last year? ☐ Yes ☐ No (Please check one)

Change Reason (Please check one) ☐ 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 ☐ Dissatisfaction ☐ I requested this PCP when I was enrolled, but was assigned a different doctor

Member Information (please print)

Full Name	_____		
Date of Birth	____/____/____	Phone #	(____) ____-____
Age	_____	Medicaid ID #	_____
Member ID #	_____	Phone #	_____
Address	_____	City	_____
State	_____	Zip Code	_____

(A new ID card will be sent out to this address within seven to ten business days.)

Signature of Member or Member's Guardian

Today's Date

Provider (Staff) Signature

Today's Date

Managed Medicaid Care Plan (MCP) Information

- CareSource; Fax Number: (937) 226-6916
- Buckeye Health Plan; Fax Number: (866) 719-5435
- Molina Healthcare; Fax Number: (888) 295-4761
- Paramount Advantage; Fax Number: (419) 887-2047
- UnitedHealthcare Community Plan; Fax Number: (866) 888-1129