CareSource

Member Requested Primary Care Provider Assignments

FAX

To: CareSource Service Center | From:

Fax: (937) 226-6916 | Pages: (including cover page)

Phone: | Date:

Re: | CC:

Member Information

Member Name: (required) _____

Member ID #: (required) _____

Member Phone/Contact # (required) _____

Please change my Primary Care Provider to: (required)

- Provider's Name: _____
- Tax ID #: _____
- Address, City, State and Zip Code: _____
- Provider's Phone Number: _____

Member's reason for requesting the change: (required)

❑ More convenient location/hours, explain: _____

❑ Referral by family/friends: _____

❑ Dissatisfaction with doctor/staff, explain: _____

❑ Problems scheduling appointments, explain: _____

❑ I requested Dr. _____ when I enrolled through Selection Services but CareSource assigned a different doctor on my CareSource ID card.

❑ Other: _____

Other family members who should also be changed to the same provider

Member Name: _____ Member Number: _____

Member Name: _____ Member Number: _____

Member Name: _____ Member Number: _____

❑ **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 by CareSource. Members can continue to be treated by the **requested** participating Primary Care Provider until the change is complete. The member should continue to use their current ID card until the new ID card is received. PCP changes can take from 1-5 weeks to process.

Member/Member Representative Signature: _____ Date: _____

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

May 2009

OH-P-183