Florida Health Care Plans®

An Independent Licensee of the Blue Cross and Blue Shield Association

REQUEST FOR PCP CHANGE

MEMBER NAME: _____ **DOB:** _____ **MRN:** _____

HOME PHONE#: _____ **WORK PHONE#:** _____

CURRENT PRIMARY CARE PROVIDER'S NAME: _____

DESIRED PRIMARY CARE PROVIDER'S NAME: **1ST CHOICE:** _____

2ND CHOICE: _____

PLEASE CHECK APPROPRIATE CHANGE REASON CODE BELOW:

- ☐ AA Initial Assignment
- ☐ C Communication Issue (Explanation of Medical Problem)
- ☐ E Inappropriate/Inadequate Care (Member's Perception)
- ☐ H Waiting Time for Appointment
- ☐ I Appointment Canceled/Rescheduled Excessively
- ☐ J Want Same PCP as Other Family Member
- ☐ L PCP Too Far – Distance Problem
- ☐ S Member wants Female PCP
- ☐ S1 Member wants Male PCP
- ☐ Q Change due to client's age
- ☐ X PCP Requested Assignment to Panel

☐ N Other: _____

****Member discharges require supporting documentation**

COMMENTS:

_____

HAVE YOU DISCUSSED THIS REQUEST WITH THE MEMBER: ☐ YES ☐ NO

EMAIL COMPLETED FORM TO !DL_PCPASSIGNMENT@FHCP.COM OR FAX TO: (386)676-7167

***ROUTINE PCP CHANGE REQUESTS PLEASE ALLOW 5 BUSINESS DAYS**

****A request to discharge a Member from a practice may take up to 14 business days to receive a decision. If approved, the Member will receive notification from FHCP.**

_____ DATE

REQUESTOR NAME (PRINTED)