Request to Change Primary Care Provider

Today's Date: ____________________________ Member's Name: ____
Please print FIRST and LAST name

Member ID #: _______________________________________ Date of Birth: _______________________________________

Additional Family Members

Member's Name: ____

Member ID #: _______________________________________ Date of Birth: _______________________________________

Member's Name: ____

Member ID #: _______________________________________ Date of Birth: _______________________________________

Member's Name: ____

Member ID #: _______________________________________ Date of Birth: _______________________________________

New Primary Care Provider's name: ____
Please print FIRST and LAST name

New Primary Care Provider's Address: ____

City: ____ State: ________ Zip: ___________ Phone #: ______________________

Effective Date: __________________________________ *This form will be accepted and the member's PCP retro changed to the first of the current month if the member is new to Molina Healthcare this month, has not received services from any other provider and the change request form is received by Molina Healthcare on or prior to the 15th of the month. If the member does not meet the above criteria the PCP change will be made effective the 1st of the following month.* ***Please attach a copy of the member's ID card, if available.***

❑ **Please check to verify that any member requesting a PCP change has not received services from any other provider this month.**

____ ________________________
Signature of Member or Delegated Guardian *Date*

Fax Completed Form to: (800) 816-3778
Questions? Please Call Member Services: (800) 869-7165

Provide your fax number to receive a confirmation of this change:
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Molina Healthcare to fill out once change is made:
Change Completed on ______________

Updated November 5, 2010