REQUEST FOR MEMBER REASSIGNMENT

COMMUNITY HEALTH CHOICE
COMMUNITY CARES

Please complete all sections below. If more than 2 Members, please attach list to this form.

PROVIDER INFORMATION

Provider Name: _____ **Contact Person:** _____

Office Address: _____ **Tax ID:** _____

_____ **NPI:** _____

Provider Phone Number: _____ **Fax Number:** _____

MEMBER INFORMATION

1. Member's Name (include guardian's name if Member is a minor) 2. Member's ID Number ***Please attach copy of 30 day notice*	Current Phone Number	Program	REASON FOR REASSIGNMENT REQUEST *(*Indicates REQUIRED Information)* *If same reason for multiple members, please attach a list that includes required Member information*			
❑ New ❑ Existing** 1_____ 2_____		❑ **Medicaid** ❑ **CHIP** ❑ **CHIP Perinatal** ❑ **Marketplace**	❑Non-Compliant ❑Abusive with Dr. &/or Staff ❑Not My Patient± ❑Unable to Contact	❑Appt. No Show _____ *Date *Nature of Visit:* ❑THSteps/❑Wellness/❑Sick ❑THSteps/❑Wellness/❑Sick ❑THSteps/❑Wellness/❑Sick	❑ER for Non-ER / Non-Urgent Cause (*List Dates):	❑Other: (*, ± Please Specify/ Include additional sheet if necessary)
❑ New ❑ Existing** 1_____ 2_____		❑ **Medicaid** ❑ **CHIP** ❑ **CHIP Perinatal** ❑ **Marketplace**	❑Non-Compliant ❑Abusive with Dr. &/or Staff ❑Not My Patient± ❑Unable to Contact	❑Appt. No Show _____ *Date *Nature of Visit:* ❑THSteps/❑Wellness/❑Sick ❑THSteps/❑Wellness/❑Sick ❑THSteps/❑Wellness/❑Sick	❑ER for Non-ER / Non-Urgent Cause (*List Dates):	❑Other: (*, ± Please Specify/ Include additional sheet if necessary)

**** REQUIRED information***
*****Please attach copy of 30 day notice to Member.***
±Please indicate name of PCP or OB if available.

Community Use Only:	**Date Member Reassigned:** _____ **Name of new Provider Assignment:** _____

Please fax this form with required documentation to Community Health Choice ▪ Attention: Member Services ▪ 713-295-2293.
Incomplete requests will not be processed.

Revised 08/2019