COMMUNITY HEALTH CHOICE

# Member Request to Change Primary Care Provider

☐ STAR ☐ CHIP ☐ CHIP P ☐ HMO D-SNP ☐ Marketplace

**Member information (Please print) *** ***Required Information***

Last Name* | First* | Middle Initial

Member ID* | Member Phone # including area code* | Member Date of Birth*

**Member's Reason for PCP Change Request**

☐ Appointment availability
☐ Already seeing requested PCP
☐ Auto-assigned by Community
☐ Convenient office location and/or hours
☐ Different primary care provider preferred
☐ Referred by family/friend
☐ Unhappy with current PCP
☐ Other: _____

**PCP Change Request (Please print)** ***Required Information***

Provider Name* | Group Name*

NPI* | Tax ID* | Fax Number*

Print Name of Member or Parent/Guardian (if under 18)

Signature of Member or Parent/Guardian (if under 18) | Date

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