Specialist as PCP Request Form

Date: _____

Member's Name: _____

Member's ID #: _____

PCP's Name (if applicable): _____

Specialist/Specialty: _____

Member's Diagnosis: _____

Describe the medical justification for selecting a specialist as PCP for this member.

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, Amerigroup and the member for whom the specialist will function as this member's PCP including providing to the member access 24 hours a day, 7 days a week.

Specialist's Signature: _____ Date: _____

Medical Director's Signature: _____ Date: _____

Member's Signature: _____ Date: _____