

**MEDICAID MANAGED CARE  
 PRIMARY CARE PROVIDER CHANGE REQUEST  
 ALLOW 24-72 HOURS FOR PROCESSING**

Your primary care provider (PCP) is the main person who gives you health care. Fill out this form to change your PCP.

**For urgent requests, please call Member Services toll free at 1-800-600-4441 (TTY 711).**

**Member information**

Member's full name	
Member's date of birth	
Legal guardian's name (if younger than age 18)	
Amerigroup Community Care member ID card number or Social Security number	
State of residence	
Medicaid ID card number	
Patient phone number	

**PCP information**

Date of request (effective date of PCP change)	
Name of new PCP	
Name of PCP staff member authorizing request (if applicable)	
New PCP phone number	
New PCP fax number	
New PCP ID number	
New PCP address	

**To be completed by patient or guardian:**

I am requesting that my PCP/my child's PCP be changed to the name listed above.

Signature of patient/guardian: \_\_\_\_\_

PCP agrees to accept above member to practice  
 (Office staff signature, if applicable): \_\_\_\_\_

**Reason for reassignment:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Autoassign/Choice issue | <input type="checkbox"/> Member/PCP moved         | <input type="checkbox"/> PCP office inconvenient |
| <input type="checkbox"/> Unhappy with PCP        | <input type="checkbox"/> Appointment availability | <input type="checkbox"/> Other/No reason         |

Please give us more detail: \_\_\_\_\_

Fax PCP requests to: **1-866-840-4993**

**Forms will not be processed  
 unless all fields are complete.**