Amerigroup RealSolutions in healthcare

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MEDICAID MANAGED CARE

PRIMARY CARE PROVIDER REASSIGNMENT REQUEST

ALLOW 24-72 HOURS FOR PROCESSING

Your primary care provider (PCP) is the main person who gives you health care. Complete this form to change your PCP. **Please note that the effective date of your PCP change is when the fax is received.**

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] ID card number or Social Security number	
State of residence	
Medicaid ID card number	
Patient phone number	

PCP information

Date of request	
Name of new PCP	
Name of PCP staff member authorizing request (if applicable)	
Telephone number of new PCP	
New PCP fax number	
New provider ID number	
New provider 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/responsible party: _____

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

Reason for reassignment:

☐ Autoassign/Choice issue
☐ Unhappy with PCP
☐ Member/PCP relocation
☐ Appointment availability
☐ PCP office inconvenient
☐ 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