



AMERIGROUP COMMUNITY CARE
PRIMARY CARE PROVIDER REASSIGNMENT REQUEST
 ALLOW 24-72 HOURS FOR PROCESSING

Your primary care provider (PCP) is the main person who provides you with health care. Complete this form if you would like to change your current 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] ID card number or Social Security number	
Medicaid ID card number	
State of residence	
Member phone number	

PCP INFORMATION

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

TO BE COMPLETED BY MEMBER OR GUARDIAN:

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

SIGNATURE OF MEMBER/RESPONSIBLE PARTY: _____

REASON FOR REASSIGNMENT:

- | | | |
|---|---|--|
| <input type="checkbox"/> Auto-assign/Choice issue | <input type="checkbox"/> Member/PCP relocation | <input type="checkbox"/> PCP office inconvenient |
| <input type="checkbox"/> Unhappy with current PCP | <input type="checkbox"/> Appointment availability | <input type="checkbox"/> Other |

Please give us more detail: _____

FAX PCP REQUESTS TO: **1-866-840-4993**

MF-NJ-0010-16
 OMHC #078-16-42

FORMS WILL NOT BE PROCESSED
 UNLESS ALL FIELDS ARE COMPLETED