Specialist as Primary Care Provider Request Form

Date_____

Member name_____

Member ID_____

Specialist name_____

Specialty_____

Primary Care Provider (PCP) name, if applicable

_____

Member diagnosis_____

_____

_____

Provide the medical justification for having a specialist as this member's PCP

_____

_____

_____

_____

_____

The signatures below indicate agreement by the specialist, member and health plan medical director that the specialist will function as this member's PCP, including providing access to care 24 hours per day and 7 days a week.

Specialist signature _____

Date _____

Medical director signature_____

Date_____

Member signature _____

Date: _____