MOLINA HEALTHCARE

Request to Change Primary Care Provider

Check appropriate line of business: ☐ Medicaid

Fields with an asterix (*) are required and must be completed

MEMBER INFORMATION:

*Member's Name: _____ *Molina ID#: _____

Please print FIRST and LAST name

*Date of Birth: _____ *Phone #: _____

*Mailing Address: _____

*City: _____ *State: _____ *Zip Code: _____

PROVIDER INFORMATION: Please provide PCP information

*Requested full PCP Name/FQHC: _____

*Office Phone #: _____

*Office Address: _____

*City: _____ *State: _____ *Zip Code: _____

Effective Date of Change (MMDDYYYY): _____

The effective date will be based on the Plan's selection/change policy

***Reason for Change—Check all that apply:**

☐ New Member—1st time selection

☐ Already established with requested PCP

☐ Requested PCP sees a family member

☐ Member Preference

☐ Member Moved

☐ Availability to get appointment/Access to care

☐ Provider left Network

☐ Provider Location

☐ Association with hospital or Medical group

☐ Language/communication barrier

☐ Wait time in providers office

☐ Quality of Care

☐ Provider Request to disenroll

☐ Other: _____

_____ *Date: _____

**Signature of Member or Authorized Representative*

Directions: *Fax the completed form to (844) 834-2155. If you have questions about completing the form, please call the number on the back of the ID card.*