Date:

Attn:

Re: UnitedHealthcare Medicaid primary care provider (PCP) change form

Please print

Fax completed form to **844-386-9287**

Name of patient: ____

Date of birth: ____

UnitedHealthcare member ID#: ____

Patient's current address *(for mailing new ID card and other updates):*

____

____

Change PCP to provider site/name: ____

UnitedHealthcare provider ID#: ____

Please change PCP effective ____________________. Patient is being seen today.

Is this patient a newborn? O Yes O No

Patient/parent/guardian's signature: ____

....

Completed by: ____

Phone #: ____

Date:____

If you do not want to receive future faxes from us, please notify us by calling us at 855-443-6845 and use ID 3034 7768. Failure to comply with your request within 30 days is unlawful.

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