United Healthcare Community Plan

Request for a change of primary care provider (PCP)

Member name:			
Member date of birth:	Member identification #:		
Member address (number, street):	City:	State:	ZIP code:
Member phone number(s):	Member phone number(s):		
Current PCP name:	Current PCP National Provider Identifier (NPI):		

Reason for change (check one):

- ☐ Member moved out of PCP service area
- ☐ Patient is already established
- ☐ PCP retired
- ☐ PCP left location
- ☐ PCP moved out of service area
- ☐ PCP is deceased
- ☐ Other (please explain) _____

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New PCP name:	New PCP NPI:		
New PCP address (number, street):	City:	State:	ZIP code:
Fax number:	Phone number:		

Member or parent/guardian signature:	Date:

Please fax this completed form to **844-386-9286.**

Note: Member signature and date required. New PCP name must be an individual PCP.

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