

# All MCP Primary Care Provider (PCP) Selection/Change Form

Please complete this form if the Primary Care Provider (PCP) on your Healthcare ID card is incorrect.  
Please fax completed form to the MCP # listed below.

## New Provider Information (please print)

|                 |                    |           |       |
|-----------------|--------------------|-----------|-------|
| PCP Name        | _____              | Clinic    | _____ |
| PCP NPI         | _____              | Tax ID    | _____ |
| PCP Address     | _____              | City      | _____ |
| State           | _____              | Zip Code  | _____ |
| PCP Phone #     | _____              | PCP Fax # | _____ |
| Effective. Date | ____ / ____ / ____ |           |       |

Have you seen this provider in the last year?  Yes  No (Please check one)

Change Reason (Please check one)  No reason – I just want different doctor on my card  More convenient location/hours  Referral by family/friend  I am an existing patient with this doctor  Dissatisfaction  I requested this PCP when I was enrolled, but was assigned a different doctor

## Member Information (please print)

|               |                    |               |                      |
|---------------|--------------------|---------------|----------------------|
| Full Name     | _____              |               |                      |
| Date of Birth | ____ / ____ / ____ | Phone #       | ( ____ ) ____ - ____ |
| Age           | _____              | Medicaid ID # | _____                |
| Member ID #   | _____              | Phone #       | _____                |
| Address       | _____              | City          | _____                |
| State         | _____              | Zip Code      | _____                |

*(A new ID card will be sent out to this address within seven to ten business days.)*

\_\_\_\_\_  
Signature of Member or Member's Guardian

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Provider (Staff) Signature

\_\_\_\_\_  
Today's Date

### Managed Medicaid Care Plan (MCP) Information

- CareSource; Fax Number: (937) 226-6916
- Buckeye Health Plan; Fax Number: (866) 719-5435
- Molina Healthcare; Fax Number: (888) 295-4761
- Paramount Advantage; Fax Number: (419) 887-2047
- UnitedHealthcare Community Plan; Fax Number: (844) 386-9286