UnitedHealthcare Community Plan

Request for a Change of Primary Care Provider (PCP)

Member Name:			
Member Date of Birth:	Member ID#:		
Member Address (No. Street):	City:	State:	Zip Code:
Member Phone Number(s):	Member Phone Number(s):		
Current PCP Name:	Current PCP 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) _____

New PCP Name:	New PCP NPI:		
New PCP Address (No. Street):	City:	State:	Zip Code:
Fax Number:	Phone Number:		

Member or Parent/Guardian Signature:	Date:

Please fax this completed form to **866-888-1129**

Note: Member Signature and Date Required. New PCP Name must be an individual PCP.