UnitedHealthcare Medicaid - **Wisconsin**
Primary Care Provider (PCP) Change Form
Please Print
Fax Completed form to: (866) 888-1129

Name of Patient: _____

Date of Birth: _____

Wisconsin Medicaid ID#: _____

Patient's Current Address:

_____

_____

Change PCP to Provider Name: _____

UnitedHealthcare Provider ID#:_____

Please Change PCP Effective_____. **Patient is being seen today.**

Is this patient a newborn? Yes No

Patient/Parent/Guardian's Signature: _____

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Completed by: _____

Phone #: _____

Date: _____