Children's Mercy
PEDIATRIC CARE NETWORK

PCP CHANGE REQUEST FORM

☐ UnitedHealthcare ☐ Missouri Care

Provider Instructions

Please complete only one form per member household. Forms completed improperly or missing the member or responsible party signature will not be processed and the primary care provider (PCP) change will not occur. Members can continue to be treated by the requested PCP until the change is completed. Members should continue to use their current Health Plan ID card until they receive their new ID card. All requests will be processed within 7-10 business days of receipt. Provider Relations will be notified of incomplete and/or invalid form submissions.

Please fax this form to: (816) 265-6211.

Part 1: Member Information *(Please use legible print.)*

Please provide the member's information:
*Required Field

_____ _____ _____
(Last Name)* (First Name)* (Middle Initial)

_____ _____ ____ / ____ / _____
(Health Plan Member ID #)* (Member Phone # with Area Code)* (Member Date of Birth)*

Part 2: PCP Change Request *(Please use legible print.)*

Please provide PCP information:
*Required Field

_____ _____ _____
(Requested PCP Full Name)* NPI (Provider ID #)*

Part 3: Additional PCP Change Requests *(Please use legible print.)*

Please provide other family members requesting change to same PCP:

Member Name: _____ Date of Birth: _____ Health Plan Member ID #: _____
Member Name: _____ Date of Birth: _____ Health Plan Member ID #: _____
Member Name: _____ Date of Birth: _____ Health Plan Member ID #: _____
Member Name: _____ Date of Birth: _____ Health Plan Member ID #: _____

Part 4: Reason for PCP Change Request

Please provide reason for the PCP change request *(Please check one of the boxes below.)*

- ☐ Different primary care provider preferred
- ☐ Referred by family/friend
- ☐ Convenient office location and/or hours
- ☐ Already a patient with requested PCP
- ☐ I requested this PCP upon enrollment, but Health Plan assigned a different PCP on my Health Plan ID card.
- ☐ Dissatisfaction with assigned PCP. Note: Health Plan will file a grievance on your behalf. You may get a call requesting more information.
- ☐ Other: _____

_____ _____
Print Name of Member or Responsible Party **Signature** of Member or Responsible Party

_____ _____
Provider *(Staff)* **Signature** **Date**

Biological Parent? Yes☐ No☐ If "no", the name of the "Responsible Party" must match exactly what Health Plan has on file for "Responsible Party". Without a match, the change cannot be processed.

Note: The member needs to present their Health Plan ID card to the requesting provider.
PCP Change effective date will be the date the health plan received the form.