Primary Care Physician (PCP) Form



Member Information	*Required Field
First Name: MI:	Last Name:
Medicaid ID*:	Date of Birth (mmddyyyy):
SSN:	Telephone number:
Mailing Address:	
City:	State: Zip Code:
PCP Change Request - Please provide PCP Information	
Requested PCP Name	NPI#
Office Address:	
City:	State: Zip Code:
Office Phone:	Effective Date (mmddyyyy): The effective date will be based upon the plan's selection/change policy.
Reason for Change from Assigned PCP - Choose all that apply. Select at least one.	
New Member - made 1st time selection	Provider Location
Already patient with requested PCP	Association with hospital or medical group
Requested PCP already sees family member	Language/communication barriers
Member Preference	Wait time in provider office
Member Moved	Availability to get appointment. Access to care
PCP Hours didn't fit member need	Established relationship w/another
Quality of Care	Provider Request to Disenroll Member
Provider Left Network	Other
Signature of Member or Authorized Representative	Date (mmddyyyy)

Print Name of Member or Authorized Representative

Directions: Please fax Member Change Data forms, with a copy of the member ID card, if available, to NH Healthy Families Member Services Department at (877) 502-7255 or mail it to NH Healthy Families Member Services,

2 Executive Park Drive, Bedford, NH 03110. If you have questions about how to complete this form or want to make this request over the phone, please call the New Hampshire Healthy Families Member Services Department, from 8 a.m. to 5 p.m. (EST), Monday through Friday, at (866) 769-3085 (TDD/TTY (855) 742-0123).