

PCP Change Request Form

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 Missouri Care 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: 1-855-247-7480

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

Please provide the member's information:

* Required Field

_____	_____	_____
(Last Name) *	(First Name)*	(Middle Initial)
_____	_____	____/____/____
(Missouri Care 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) *	(Missouri Care 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: _____	Missouri Care Member ID #: _____
Member Name: _____	Date of Birth: _____	Missouri Care Member ID #: _____
Member Name: _____	Date of Birth: _____	Missouri Care Member ID #: _____
Member Name: _____	Date of Birth: _____	Missouri Care Member ID #: _____
Member Name: _____	Date of Birth: _____	Missouri Care 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 Missouri Care assigned a different PCP on my Missouri Care ID card.
- Dissatisfaction with assigned PCP. Note: Missouri Care 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 Missouri Care has on file for "Responsible Party". We cannot process this change without a match.

Please call: 1-800-322-6027 if you have questions about this form.

Note: The member needs to present their Missouri Care ID card to the requesting provider. PCP Change effective date will be the date Member Services receives the PCP Change Request fax.