REQUEST TO CHANGE MY PRIMARY CARE PROVIDER (PCP)

Member Information

Member Full Name: _____ Member Birthday: _____

Member ID #: _____

Member Address: _____

City: _____ State: _____ Zip: _____

Member Phone: _____

Requested New PCP

Doctor's Full Name: _____ Group/Clinic Name: _____

Office Address: _____

City: _____ State: _____ Zip: _____

Doctor Phone: _____ Doctor Fax: _____

Doctor Email: _____ Requested Effective Date (mm/dd/yyyy): _____

Reason for Requesting Change

(Check all that apply)

- ☐ This doctor is already my PCP
- ☐ This doctor sees another family member
- ☐ This PCP is my personal preference
- ☐ I have moved
- ☐ Office hours did not fit my needs
- ☐ Quality of care did not fit my needs
- ☐ Office wait times were too long
- ☐ Took too long to get an appointment
- ☐ Office is too far away/hard to get to
- ☐ Other: _____

Member/Authorized Representative Printed Name: _____

Member/Authorized Representative Signature: _____ Date: _____

PLEASE SEND YOUR COMPLETED FORM TO:

Louisiana Healthcare Connections, ATTN: Member Services
P.O. Box 84180, Baton Rouge, LA 70884

Or fax to: 1-866-768-9374

HAVE QUESTIONS OR NEED HELP?

Call us at 1-866-595-8133 (TTY: 711),
Monday through Friday, 7 a.m. to 7 p.m.