Request To Change My Doctor *(Primary Care Provider)* Form

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Please complete this form to **CHANGE** *your doctor (Primary Care Provider). If you have any questions about this form, please call Member Services at* ***1-866-595-8133*** *or TDD/TTY (our deaf and hearing loss number) 1-877-285-4514, Monday–Friday, 7 a.m. to 7 p.m. (Central), and we will be happy to assist you.*

Personal Information

Your Medicaid ID # _____ Your Social Security # _____

Your Birth Date *(mm/dd/yyyy)* _____

Your First Name _____ Your Last Name _____ Your Middle Initial ____

Your Mailing Address _____ City _____ State _____ Zip Code _____

Your Home Phone _____ Your Cell Phone _____

Requested New Doctor *(Primary Care Provider)*

First Name of Doctor *(Primary Care Provider)* _____

Last Name of Doctor *(Primary Care Provider)* _____

Office Address of Doctor *(Primary Care Provider)* _____

City _____ State _____ Zip Code _____

Phone Number of Doctor *(Primary Care Provider)* _____

Request New Doctor *(Primary Care Provider)* by *(mm/dd/yyyy)* _____

Reason For Request To Change Doctor *(Primary Care Provider)*

Please check all that apply

- ☐ Already my doctor *(Primary Care Provider)*
- ☐ Already sees another family member
- ☐ My personal preference
- ☐ With a preferred hospital or medical group
- ☐ I have moved
- ☐ Office hours do not fit my needs
- ☐ Quality of care does not fit my needs
- ☐ Office wait times are too long
- ☐ Takes too long to get an appointment
- ☐ Office is too far away/hard to get to
- ☐ OTHER *(please specify)* _____

Signatures

Member Signature *(or your Health Information representative)* _____

Printed Name of Member *(or your Health Information representative)* _____

Date *(mm/dd/yyyy)* _____

Once you have completed this form, please mail it to us in the postage-paid envelope labeled, *"Member Services."*

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Call Monday–Friday, 7 a.m. to 7 p.m. (Central)

Toll Free: **1-866-595-8133**
TDD/TTY (deaf and hearing loss number):
1-877-285-4514

www.LouisianaHealthConnect.com