Primary Care Provider Reassignment Form

PCP Information

Date:		
Office Name:		
Office Address:		
City, State, Zip:		
Office Phone:		
Office Fax:		
Staff Member Initiating Request:*		
Name of New PCP and Provider ID #:*		ID #:_____
		ID #:_____
		ID #:_____
	Other:	ID #:_____
New PCP Office Address:*		
New Office Phone and Fax #:*	Phone:	Fax:

Member Information

Member's Full Name:*	
Member's Date of Birth:*	
Meridian Member ID:*	
Meridian Member Authorization* Signature of Member, Parent, or the Responsible Party is *required* to approve PCP change	**X**_____ Printed Name:

*All fields containing an asterisk must be completed. Failure to provide all required information above will result in this request not being processed.

For questions, please call Member Services at **1-888-437-0606** (TTY: **711**).

Fax completed Primary Care Provider Reassignment Form to: 833-667-1288.