Member PCP Change Request Form

Please fax to Member's Health Plan

Select one health plan below. Use a separate form for more than one health plan being selected.

☐ nebraska total care — Fax 1-844-305-8372

☐ UnitedHealthcare Community Plan — Fax 1-888-999-0649

☐ Healthy Blue — Fax 1-844-886-2759

MEMBER #1 INFORMATION					
First Name		Last Name		Middle Initial	
Mailing Address				Phone #	
City		State		Zip	
Date of Birth		Member ID #			
PCP Name				PCP ID # (Optional)	
PCP Address				PCP Phone #	
PCP City		PCP State		PCP Zip	
Reason for PCP Change:	☐ Already patient with PCP		☐ Network Access		
☐ Other:	☐ Provider Left Network		☐ Quality of Care Concerns		

Additional PCP change requests can be made below to a maximum of 3 requests per form for one plan.

☐ Address for below member is same as above:

MEMBER #2 INFORMATION					
First Name		Last Name		Middle Initial	
Mailing Address				Phone #	
City		State		Zip	
Date of Birth		Member ID #			
PCP Name				PCP ID # (Optional)	
PCP Address				PCP Phone #	
PCP City		PCP State		PCP Zip	
Reason for PCP Change:	☐ Already patient with PCP		☐ Network Access		
☐ Other:	☐ Provider Left Network		☐ Quality of Care Concerns		

☐ Address for below member is same as above:

MEMBER #3 INFORMATION					
First Name		Last Name		Middle Initial	
Mailing Address				Phone #	
City		State		Zip	
Date of Birth		Member ID #			
PCP Name				PCP ID # (Optional)	
PCP Address				PCP Phone #	
PCP City		PCP State		PCP Zip	
Reason for PCP Change:	☐ Already patient with PCP		☐ Network Access		
☐ Other:	☐ Provider Left Network		☐ Quality of Care Concerns		

Member agrees and willingly selects new PCP:

Print Name of Member or Responsible Party: _____

Signature of Member or Responsible Party: _____ Date: _____

Provider Staff Assisting Member: _____ Provider Staff Phone: _____