



Louisiana Healthcare Connections PCP Change Request Form

Member Information

First Name: _____ Last Name: _____ M.I. _____
 Member ID: _____ SSN: _____ DOB: _____
 Address: _____
 Phone Number: () _____

PCP Change Request

Please Provide PCP Information

Requested PCP Name: _____ Provider ID: _____
 Office Address: _____
 City: _____ Zip Code: _____
 Office Phone: () _____
 Effective Date: _____

Reason for Change from Assigned PCP

- | | |
|---|--|
| <input type="checkbox"/> Already patient with requested PCP | <input type="checkbox"/> Association with hospital or medical group |
| <input type="checkbox"/> Requested PCP already sees family member | <input type="checkbox"/> Language/communication barriers |
| <input type="checkbox"/> Member Preference | <input type="checkbox"/> Wait time in provider office |
| <input type="checkbox"/> Member Moved | <input type="checkbox"/> Availability to get appointment. Access to care |
| <input type="checkbox"/> PCP Hours didn't fit member need | <input type="checkbox"/> Association with hospital or medical group |
| <input type="checkbox"/> Quality of Care | <input type="checkbox"/> Established relationship w/ another |
| <input type="checkbox"/> Provider Location | <input type="checkbox"/> Other |

Signature of Member or Authorized Representative

Date

Printed Name of Authorized Representative

Directions: Please fax Member Change Data forms, with a copy of the member ID card, if available, to Louisiana Healthcare Connections Member Services Department at 1-866-7689374, or mail it to Louisiana Healthcare Connections Member Services, 8550 United Plaza Blvd, Baton Rouge, LA 70809.

If you have questions about how to complete this form, please call the Louisiana Healthcare Connections Member Services Department, Monday through Friday, 7 a.m.-7 p.m. at 1-866-595-8133 (TDD/TTY 1-877-285-4514).