



**MEDICAID MANAGED CARE**  
**PRIMARY CARE PHYSICIAN REASSIGNMENT REQUEST**  
 ALLOW 24 - 72 HOURS FOR PROCESSING

YOUR PRIMARY CARE PHYSICIAN (PCP) IS THE MAIN PERSON WHO GIVES YOU HEALTH CARE. COMPLETE THIS FORM TO CHANGE YOUR PCP.

For urgent requests, please call Member Services toll free at 1-800-600-4441.

**MEMBER INFORMATION**

Member's Full Name	
Member's Date of Birth	
Legal Guardian's Name (If younger than age 18)	
Amerigroup ID Card Number or Social Security Number	
State of Residence	
Medicaid ID Card Number	
Patient Phone Number	

**PCP INFORMATION**

Date of Request (Effective Date of PCP Change)	
Name of New PCP	
Name of New PCP staff member processing request (If applicable)	
Telephone Number of New PCP	423-547-9400
New PCP Fax Number	423-547-9401
New Provider ID Number	
New Provider Address	1503 W. Elk Ave Ste 12 Eliz. TN 37643

**TO BE COMPLETED BY PATIENT OR GUARDIAN:**

I am requesting that my PCP/my child's PCP be changed to the name listed above.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY: \_\_\_\_\_

SIGNATURE OF NEW PCP (Not required): \_\_\_\_\_

**REASON FOR REASSIGNMENT:**

- |   |   |  |
|---|---|--|
| <input checked="" type="checkbox"/> Autoassign/Choice Issue | <input type="checkbox"/> Member/PCP Relocation    | <input type="checkbox"/> PCP Office Inconvenient |
| <input type="checkbox"/> Unhappy with PCP                   | <input type="checkbox"/> Appointment Availability | <input type="checkbox"/> Other/ No Reason        |

Please give us more detail: To est. pt. wrong rep a file

FAX PCP REQUESTS TO: **1-866-840-4993**

FORMS WILL NOT BE PROCESSED  
 UNLESS ALL FIELDS ARE COMPLETED