

Request for Primary Care Physician (PCP) or Medical Group Change Form

Physician Name:			
Location:			
Physician ID #:			
IPA/Med Grp #:			
Reason for Request:			
	Member Name(s)	Date of Birth	Subscriber #
1			
2			
3			
Please check Yes or No to answer the following questions:			Yes
Is the member currently hospitalized?			No
Is the member in her third trimester of pregnancy?			
Did the member receive any services with the assigned PCP/medical group?			
Is the member currently receiving treatment?			
Is the member scheduled to receive future treatment (surgery, specialist care, etc.)?			
Has the member delivered a baby within the past 60 days?			
Does the member have an infant less than 60 days old who is currently in the hospital?			
Did the member receive any services in the emergency room?			
<p>Disclaimer: Any prior authorizations submitted to or approved by the existing PCP/medical group will no longer be valid with the new PCP/medical group. If a member becomes hospitalized prior to the effective date of change, the member will be changed back to existing PCP/medical group until the episode of care is complete. If the mother of a newborn requests a PCP/medical group change prior to her first postpartum visit (which usually occurs within 40 days of delivery), the change cannot be processed. (The only exception to this is if the requested PCP is in the same medical group).</p>			
Member signature: _____			
Member address: _____			
Member telephone #: _____			
Name of staff completing transfer: _____			
Staff member's telephone #: _____ Ext. #: _____ Fax #: _____			
Additional information: _____			
Today's Date: ____/____/____		<input type="checkbox"/> Fax <input type="checkbox"/> Email Effective date: ____/____/____ (Please check one.)	
OFFICE USE:			
Date change entered: ____/____/____		Rep's Name: _____	

Please fax to:
Attention: Arizona Complete
Health-Complete Care Plan

AZ Medicaid Member Services
866-528-9921