

Primary Care Provider Change Form



Priority Health • PO Box 205 • Grand Rapids, MI 49501-0205

(Please complete this form or contact us directly to change your Primary Care Provider.)

If you would like assistance with your change, please call Customer Service at 800 446-5674 Fax to 616 942-5242

SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name	First Name	Middle Initial	Social Security Number
Employer Name			Group Number

SECTION 2 - PRIMARY CARE PROVIDER

This change becomes effective the first of the month following the date your form is received by Priority Health.

Employee/Dependent Name	Priority Health Primary Care Provider (PCP)	PCP Address/ID Code	Have you or this dependent ever seen this provider?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

REASON FOR CHANGE	<input type="checkbox"/> Member moved	<input type="checkbox"/> Communication problems with PCP/office staff
	<input type="checkbox"/> PCP moved	<input type="checkbox"/> Hard time getting appointments
	<input type="checkbox"/> PCP left practice	<input type="checkbox"/> Wait time in the office too long
	<input type="checkbox"/> Office location is hard to get to	<input type="checkbox"/> Not satisfied with office staff
	<input type="checkbox"/> PCP No Longer with Priority Health	<input type="checkbox"/> PCP/office staff rude or uncaring
	<input type="checkbox"/> Did not want PCP Priority Health assigned	<input type="checkbox"/> Poor quality of medical care
	<input type="checkbox"/> Personal Preference	

SECTION 3 - AUTHORIZATION FOR PRIMARY CARE PROVIDER CHANGE

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that I must sign and date this form before it will be processed.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

X _____
Employee Signature Date

For Priority Health Use Only	Date Received	Processor	Code	Date Processed
	Effective Date			

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In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history or any requests for or receipt of genetic services.