

PCP: Member discharge form

Incomplete forms will be returned to the provider and may delay the request.

Date of request _____

Member's name (one member or family per form) _____

Member's Priority Health contract number _____

Member's date of birth _____

Practice name _____

Practice contact name _____

Practice contact telephone _____

Practice contact email _____

Member transfers to a new PCP will be effective the first of the month following 30 days from the discharge letter date.

Date of notification of discharge to member _____

Reason for discharge _____

Attach a copy of the discharge letter.

Send completed form to:

Mail: Priority Health
Attn: PCP Discharge, MS 1105
1231 East Beltline NE
Grand Rapids, MI 49525-4501

Fax: Attention: PCP Discharge
616 975-8828