Change form

PriorityHealth

Member changes must be received by Priority Health within 31 days of the event.

MEMBER INFORMATION

Member's last name	First name	M.I.	Social security number	Member ID number
			– –	

Phone number that we may use to contact you	☐ Landline (home phone) ☐ Cell phone	Alternate number that we may use to contact you (*optional*)	☐ Landline (home phone) ☐ Cell phone

Email

☐ **Name change** For: ☐ Member ☐ Dependent	New last name	First name		
☐ **Address/phone change** For: ☐ Member ☐ Dependent	Street address	City	State	ZIP
	Phone number that we may use to contact you ☐ Landline (home phone) ☐ Cell phone	Alternate number that we may use you contact you (*optional*) ☐ Landline (home phone) ☐ Cell phone		

☐ **Dependent information (if you have more than 4 dependent changes, complete an additional change form)**

1	Last name	First name	M.I.	Social security number – –	Sex ☐ Male ☐ Female
	Birth date / /	Relation to member	Street address	City, State	ZIP
	Primary care provider (Required for HMO & POS)	PCP address		Has this dependent ever seen this provider? ☐ Yes ☐ No	
2	Last name	First name	M.I.	Social security number – –	Sex ☐ Male ☐ Female
	Birth date / /	Relation to member	Street address	City, State	ZIP
	Primary care provider (Required for HMO & POS)	PCP address		Has this dependent ever seen this provider? ☐ Yes ☐ No	
3	Last name	First name	M.I.	Social security number – –	Sex ☐ Male ☐ Female
	Birth date / /	Relation to member	Street address	City, State	ZIP
	Primary care provider (Required for HMO & POS)	PCP address		Has this dependent ever seen this provider? ☐ Yes ☐ No	
4	Last name	First name	M.I.	Social security number – –	Sex ☐ Male ☐ Female
	Birth date / /	Relation to member	Street address	City, State	ZIP
	Primary care provider (Required for HMO & POS)	PCP address		Has this dependent ever seen this provider? ☐ Yes ☐ No	

AUTHORIZATION

I authorize Priority Health to make the changes indicated above for my dependents and me. I understand that Priority Health may request pertinent sworn statements if needed and 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 _____

Member signature Date

continued>

COMPLETED BY EMPLOYER

☐ **Plan change (if checked please also check one of the following)** ☐ **HMO** ☐ **POS** ☐ **PPO** ☐ **HbC** ☐ **HRA** ☐ **HSA**
Plan option (if applicable) ☐ **High** ☐ **Mid** ☐ **Low**

Employer name	Group number	Sub group number	Sub group ☐ New ☐ Existing	Class	Class ☐ New ☐ Existing

Employer/representative signature	Date / /

Reasons for additions ☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of other coverage *(proof required)* ☐ Open enrollment ☐ Court order *(proof required)* ☐ Other: _____	Effective date / /

Reasons for dependent termination ☐ Marriage of dependent ☐ Divorce ☐ Death ☐ Lost eligibility ☐ Other: _____	Date participant notified of coverage termination / /	Date coverage ended / /

Reasons for termination of entire contract ☐ Terminated employment ☐ Lay off ☐ Leave of absence ☐ Changed health plans ☐ Moved out of the area ☐ Death ☐ COBRA terminated ☐ Dissatisfied ☐ Other: _____	Date participant notified of coverage termination / /	Date coverage ended / /

FOR PRIORITY HEALTH USE ONLY

Date received / /	Processor	Code	Date processed / /

SUBMIT FORM

By fax:
616.942.5242
OR
By mail:
Priority Health
MS 2275
1231 East Beltline NE
Grand Rapids, MI 49525