Primary Care Provider (PCP) Form ONE MEMBER PER FORM

absolute total care™
Healthy Connections

Member information ***Required field**

First name: MI: Last name:

Medicaid ID*: Date of birth (mmddyyyy):

SSN: Telephone number: - -

Mailing address:

City: State: Zip code:

PCP change request — Please provide PCP Information

Requested PCP name NPI#

Office address:

City: State: Zip code:

Office phone: - - Effective date (mmddyyyy):

The effective date will be based upon the plan's selection/change policy.

Reason for change from assigned PCP — Choose all that apply. Select at least one.

- ☐ New member — made first-time selection
- ☐ Already patient with requested PCP
- ☐ Requested PCP already sees family member
- ☐ Member preference
- ☐ Member moved
- ☐ PCP hours didn't fit member need
- ☐ Quality of care
- ☐ Provider left network
- ☐ Provider location
- ☐ Association with hospital or medical group
- ☐ Language/communication barriers
- ☐ Wait time in provider office
- ☐ Availability to get appointment; access to care
- ☐ Established relationship w/another
- ☐ Provider request to disenroll member
- ☐ Other

_____

Signature of member or authorized representative

Date (mmddyyyy)

_____

Print name of member or authorized representative

Directions: Please fax Member Change Data forms, with a copy of the member ID card, if available, to the Absolute Total Care Eligibility Department at **1-866-224-3422** or mail it to the Absolute Total Care Eligibility Department at 1441 Main Street, Suite 900, Columbia, SC 29201. If you have questions about how to complete this form or want to make this request over the phone, please call the Absolute Total Care Member Services Department from 8 a.m. to 6 p.m. (EST), Monday through Friday at **1-866-433-6041** (TTY 711).

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