



**Florida
Health Care
Plans**



An Independent Licensee of the Blue Cross and Blue Shield Association

REQUEST FOR PCP CHANGE

MEMBER NAME: _____ **DOB:** _____ **MRN:** _____

HOME PHONE#: _____ **WORK PHONE#:** _____

CURRENT PRIMARY CARE PROVIDER'S NAME: _____

DESIRED PRIMARY CARE PROVIDER'S NAME: **1ST CHOICE:** _____

2ND CHOICE: _____

PLEASE CHECK APPROPRIATE CHANGE REASON CODE BELOW:

- | | |
|---|---|
| <input type="checkbox"/> AA Initial Assignment | <input type="checkbox"/> O Prior FHCP Physician, now Recontracting with FHCP |
| <input type="checkbox"/> B Communication Issue (Unable to Understand) | <input type="checkbox"/> P Physician Requested Change |
| <input type="checkbox"/> C Communication Issue (Explanation of Medical Problem) | <input type="checkbox"/> Q Change due to client's age |
| <input type="checkbox"/> C1 Physician/Staff Failed to Call Pt after Patient Request | <input type="checkbox"/> R Client Deleted |
| <input type="checkbox"/> C2 Physician/Staff Failed to Call Pt with Test Results | <input type="checkbox"/> S Member wants Female PCP |
| <input type="checkbox"/> D Lack of Confidence | <input type="checkbox"/> S1 Member wants Male PCP |
| <input type="checkbox"/> E Inappropriate/Inadequate Care (Member's Perception) | <input type="checkbox"/> T Member could/would not Give a Reason for Change |
| <input type="checkbox"/> F Physician Attitude | <input type="checkbox"/> U Change from Default PCP after being active 60 days |
| <input type="checkbox"/> G Physician Staff Attitude | <input type="checkbox"/> V Updated Provider in Error |
| <input type="checkbox"/> H Waiting Time for Appointment | <input type="checkbox"/> W New Member Reassigned |
| <input type="checkbox"/> I Appointment Canceled/Rescheduled Excessively | <input type="checkbox"/> X PCP Requested Assignment to Panel |
| <input type="checkbox"/> J Want Same PCP as Other Family Member | <input type="checkbox"/> Y Dental Change Only |
| <input type="checkbox"/> K Prefer Main Health Care Facility | <input type="checkbox"/> Z1 Returning Member to PCP & FHCP |
| <input type="checkbox"/> L PCP Too Far – Distance Problem | <input type="checkbox"/> Z2 New Member who has PCP from prior insurance |
| <input type="checkbox"/> M Physician Terminated Contract with FHCP | |
| <input type="checkbox"/> N Other: _____ | |

COMMENTS: _____

HAVE YOU DISCUSSED THE ISSUE CHECKED ABOVE WITH MEMBER SERVICES: YES NO

REQUESTOR SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY

CHANGED TO PRIMARY CARE PHYSICIAN: _____

CHANGE MADE BY: _____ DATE: _____

DATE CONFIRMATION OF CHANGE SENT TO MEMBER: _____