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# Primary Care Provider (PCP) Form

magnolia health

**Member Information** *Required Field

First Name: MI: Last Name:

Member 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 1st 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 Magnolia Member Services Department at **(877) 779-5219** or mail it to Magnolia Member Services, 1020 Highland Colony Parkway, Suite 502, Ridgeland, MS 39157. If you have questions about how to complete this form or want to make this request over the phone, please call the Magnolia Member Services Department, from 8 a.m. to 5 p.m. (CST), Monday through Friday, at **(866) 912-6285**, Mississippi Relay 711).