Primary Care Physician

ONE MEMBER PER FORM

western sky community care

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 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 PCP
- ○ Provider Request to Disenroll Member
- ○ Other

Signature of Member or Authorized Representative Date (mmddyyyy)

Print Name of Member or Authorized Representative

Directions: Please **FAX** this form, with a copy of the Member ID card, if available, to Western Sky Community Care Member Services Department at **1-844-320-2479** or mail it to Western Sky Community Care Member Services, 5300 Homestead Rd. NE, Albuquerque, NM 87110. If you have questions about how to complete this form or want to make this request over the phone, please call the Western Sky Community Care Member Services Department, from 8 a.m. to 5 p.m., Monday through Friday, at 1-844-543-8996 (TTY: 711).