PCP Change Form

This form *will not be processed* if the signature of the member or his/her parent or guardian is not supplied below.

Today's Date: ____________________

To Be Completed by the Member

Member ID#: ____________________________________

Member Name: ____________________________________
(Please print)

Parent/Guardian Name: ____________________________________
(if applicable) *(Please print)*

Reason for Changing PCP: ____________________________________

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Signature of Member
or Parent/Guardian: ____________________________________
(*Signature required)*

Name of New Medical PCP: ____________________________________

Address of New PCP: ____________________________________

Name of New **OB/GYN:** ____________________________________

Effective Date of Change: __________________ ☐ First day of the upcoming month

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Fax the completed form to:

YourCare Health Plan 1-888-273-8296

(Rev. 1/17)

P.O. Box 240 Pittsford, NY 14534 www.yourcarehealthplan.com