



**PRIORITY HEALTH**

P.O. Box 205  
Grand Rapids, MI 49502-0472

# PRIMARY CARE PROVIDER CHANGE FORM

(Please complete this form or contact us directly to change your Primary Care Provider.)

If you would like assistance with your change,  
please call Customer Service at 800 446-5674

## SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name	First Name	Middle Initial	Social Security Number — — —
Employer Name			Group Number

## SECTION 2 - PRIMARY CARE PROVIDER

**This change becomes effective the first of the month following the date your form is received by Priority Health.**

Employee/Dependent Name	Priority Health Primary Care Provider (PCP)	PCP Address/ID Code	Have you or this dependent ever seen this provider?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

REASON FOR CHANGE	<input type="checkbox"/> Member moved	<input type="checkbox"/> Communication problems with PCP/office staff
	<input type="checkbox"/> PCP moved	<input type="checkbox"/> Hard time getting appointments
	<input type="checkbox"/> PCP left practice	<input type="checkbox"/> Wait time in the office too long
	<input type="checkbox"/> Office location is hard to get to	<input type="checkbox"/> Not satisfied with office staff
	<input type="checkbox"/> PCP No Longer with Priority Health	<input type="checkbox"/> PCP/office staff rude or uncaring
	<input type="checkbox"/> Did not want PCP Priority Health assigned	<input type="checkbox"/> Poor quality of medical care
	<input type="checkbox"/> Personal Preference	

## SECTION 3 - AUTHORIZATION FOR PRIMARY CARE PROVIDER CHANGE

**I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that I must sign and date this form before it will be processed.**

**Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.**

X \_\_\_\_\_  
Employee Signature Date

<b>For Priority Health Use Only</b>	Date Received	Processor	Code	Date Processed
	Effective Date			

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# CHANGE FORM

(Member changes must be received by Priority Health within 31 days of the event.)

## SECTION 1 - EMPLOYEE INFORMATION

Employee's Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
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## SECTION 2 - CHANGES (Please complete only those changes which apply.)

<input type="checkbox"/> <b>ADDRESS/PHONE CHANGE</b>	Street Address	City
State	Zip Code	Home Phone ( ) - ( ) - Work Phone ( ) - ( ) -

<input type="checkbox"/> <b>NAME CHANGE</b>	New Last Name	Former Last Name
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<input type="checkbox"/> <b>DEPENDENT CHANGE</b> (If you have more than 4 dependent changes please complete an additional change form).	Date Change Occurred / /	Reason for Change Add <input type="checkbox"/> Delete <input type="checkbox"/>		
<b>1</b>	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	
<b>2</b>	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	
<b>3</b>	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	
<b>4</b>	Last Name	First Name	Middle Initial	Social Security Number _ _ - _ _
	Birth Date / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Relation to Employee	Priority Health Primary Care Provider (PCP) (REQUIRED)
	Has this dependent ever seen this provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		PCP Address/ID Code	

If you, or your spouse, or any dependents are covered by Medicare or any other insurance policy providing medical benefits, please complete this section.

WHERE ARE CLAIMS SENT?	Company Name	Company Address
POLICYHOLDER INFORMATION	Name of Policyholder	Birthdate / /
	Family Member(s) Covered (1) (2) (3) (4)	Policy Effective Date / /
REASON FOR MEDICARE	End Stage Renal Disease <input type="checkbox"/>	Disabled <input type="checkbox"/>
	Over Age 65 <input type="checkbox"/>	Over Age 65 and Working <input type="checkbox"/>
		Effective Date / /

## SECTION 3 - AUTHORIZATION

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

X \_\_\_\_\_  
Employee Signature Date

<b>For Employer Use Only</b>	Employer Name	Group Number	Sub Group Number	Class
	Employer/Representative Signature	Date / /		
	Plan Change <input type="checkbox"/> (If checked, please also check one of the following) HMO <input type="checkbox"/> POS <input type="checkbox"/>			
	REASONS FOR ADDITIONS Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Loss of other coverage (Proof Required) <input type="checkbox"/> Other _____			Effective Date / /
	REASONS FOR DELETIONS Marriage of Dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Lost Eligibility <input type="checkbox"/> Other <input type="checkbox"/> _____			Date Coverage Ended / /
	REASON FOR TERMINATION OF ENTIRE CONTRACT Terminated Employment <input type="checkbox"/> Lay Off <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Changed Health Plans <input type="checkbox"/> Moved out of area <input type="checkbox"/>		Date Occurred / /	Date Coverage Ended / /
	Death <input type="checkbox"/> COBRA Terminated <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Other <input type="checkbox"/> _____			

<b>For Priority Health Use Only</b>	Date Received / /	Processor	Code	Date Processed / /
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