Primary Care/Main Doctor Detail
Name: ______________________________
Phone: ______________________________
Agree to Take the Patient Listed Below: ______________________________

Primary Care Physician (PCP)/Main Doctor Change Form

FOR MEMBERS

Do you want to change your main doctor? Here is what you can do:

- You may pick one main doctor or clinic for the whole family.
- Member may choose his/her own main doctor or clinic.
- You must list only one family member on this form even if you select the same main doctor or clinic.

Name: ____________________ **Cell Phone:** ______________ **Home Phone:** ______________

Address: ________________________ **City/State:** ______________ **Zip:** __________

All items below MUST be filled out and faxed today | Fax to 209-461-2550			
First Name:	**Last Name:**	**Date of Birth:**	**CIN# or HPSJ/MVHP ID:**
Main Doctor or Main Doctor's Clinic Name:		**Place/Address:**	

New Member ID cards will be mailed to you within 14 days of choosing your new main doctor or clinic. Always carry your HPSJ/MVHP ID card with you. **Have questions?** Call 1-888-936-PLAN (7526) TTY 711.

FOR PROVIDERS

Note: *If the member has* ***not*** *accessed care from their assigned PCP during this month, the change can be made effective to the 1st of this month. If not, the PCP change will be made the 1st of next month.*

Has member listed above been seen by another PCP this month? Yes No

Member facts: Existing Member New Patient

Was member seen in the office today? Yes No

Reason for today's visit: ______________________________

Member's signature: ______________________________ **Date:** ______________

Primary Care/Main Doctor Detail
Name: ______________________
Phone: ______________________
Agree to Take the Patient Listed Below: ______________________

Formulario de Cambio de Doctor Principal/Médico Primario

PARA MIEMBROS

¿Desea cambiar de doctor principal? Puede hacer esto:

- Puede elegir un doctor o una clínica principal para toda la familia.
- El miembro puede elegir su propio doctor o clínica principal.
- Debe incluir solo a un miembro de la familia en este formulario, incluso si elige el mismo doctor principal o clínica principal.

Nombre: ______________ **Teléfono celular:** __________ **Teléfono de la casa:** __________

Dirección: ________________ **Ciudad/Estado:** ____________ **Código postal:** ______

Los datos a continuacion se DEBEN completar y enviar por fax hoy mismo al 209-461-2550			
Nombre:	**Apellido:**	**Fecha de Nacimiento:**	**N.º de identificación de miembro de HPSJ/MVHP:**
Nombre del doctor o de la clínica principal:		**Lugar/dirección:**	

Le enviaremos las nuevas tarjetas de identificación de miembro dentro de 14 días de haber elegido a su nuevo doctor o clínica principal. Asegúrese de llevar siempre con usted la tarjeta de identificación de Health Plan/Mountain Valley Health Plan. **¿Tiene preguntas?** Llame al 1-888-936-PLAN (7526) TTY 711.

FOR PROVIDERS

Note: *If the member has* ***not*** *accessed care from their assigned PCP during this month, the change can be made effective to the 1st of this month. If not, the PCP change will be made the 1st of next month.*

Has member listed above been seen by another PCP this month? Yes No

Member facts: Existing Member New Patient

Was member seen in the office today? Yes No

Reason for today's visit: ______________________________

Member's signature: ______________________ **Date:** __________

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