mercy care

Member's PCP Change Request Form

I, _____am requesting to be assigned to the following Primary Care Physician (PCP): _____effective_____.

I understand it is my choice to select a PCP, and I am freely requesting this change be processed on my behalf by _____ personnel. I have recorded my information below to confirm my identity.

Member's Name: _____

Date of Birth: _____**AHCCCS ID number:** _____

Mailing Address: _____

Contact Telephone Number: _____

Member's Signature: _____**Date:** _____

Witness Name: _____**Date**:_____

For Office Use Only

Demographic Information of Group Requesting Change

Group Name: _____

Address: _____

Tax Id Number: _____

PCP Information

PCP's Name: _____

Physical Address (Location): _____

PCP's Individual NPI: _____

Office Staff Name (Print):_____Date:_____

Email Request to: MBU-MMIC_Enrollment@aetna.com **or**
FAX to: 602-414-7663