PCP Change Request

DIRECTIONS:

Use this form to request a change to your Primary Care Provider (PCP). If you have questions about this form, call Member Services at **866-329-4701 (toll-free) / 711 (TTY)**.

Send the completed form with a copy of the member ID card to:
Mail: IlliniCare Health
PO Box 92050, Elk Grove Village IL 60009-2050
Fax: 855-254-1790

Member Information (please print)

Member Name:	Address:
Member ID Number:	City: State: Zip:
Member Date of Birth:	Phone:

PCP You Want to Change To

Requested PCP Name:	Office Address:
National Provider Identifier (NPI):	City: State: Zip:
Office Phone:	Effective Date:

Reason for Change

- ○ Already a patient with requested PCP
- ○ Requested PCP already sees family member
- ○ Member preference
- ○ Member moved
- ○ Current PCP hours do not fit member needs
- ○ Quality of care
- ○ Provider location
- ○ Language/communication barriers
- ○ Wait time in provider office
- ○ Appointment availability
- ○ Office/Building physical access barriers
- ○ Current PCP fails to provide accommodations
- ○ Association with hospital or medical group
- ○ Established relationship with requested PCP
- ○ Other ______________________

Signature of Member or Authorized Representative:	Date:
Printed Name of Authorized Representative:	