Primary Care Provider Change Request Form

Your primary care provider (PCP) is the main person you see for healthcare. If you want to request a PCP that is in the Amerigroup Washington, Inc. network and a participating provider, there are two options to request this.

Complete this form and fax it to **866-840-4993** the same day as the requested effective date. Please allow 24 to 72 hours for processing. Be advised that the effective date will be the date that the fax is sent in and received unless the requested date is in the future.

The second option is to call Member Services toll-free at **800-600-4441 (TTY 711)** Monday through Friday from 8 a.m. to 5 p.m. PT and request the change through our Provider Services team. The effective date will be the date you call and place the request unless the requested date is in the future. It is important that you call and make this request the same day as the requested effective date.

Instructions:

- **Forms will not be processed unless all fields are completed.**
- **Please *clearly* print the information below.**
- **If there is an error made on the form, please discard and begin with a new form.**

Member/patient information

Full name	
Date of birth (MM/DD/YYYY)	
Amerigroup ID number (listed on member ID card)	
Medicaid ID number (listed on ID card)	
Phone number	
Legal guardian’s name (if younger than 18)	

New PCP information

Date of request or effective date (MM/DD/YYYY) The effective date **will** be the date that the fax is sent in and received or the date the phone request option takes place **unless** the requested date is in the future.	

Name of requested PCP	
Provider ID number	
Provider address	
Provider phone number	
Provider fax number	

Reason for request:

☐ I did not choose my last PCP.
☐ I was unhappy with my last PCP.
☐ I had trouble getting appointments with my last PCP.
☐ I moved or my PCP moved.
☐ My PCP's office was too far away or too hard to get to.
☐ Other (please explain below).

Please give us more detail: ____

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Signature of member or responsible party:

Sign: _________________________________ Date: ____________________

Please fax this form to **866-840-4993** immediately to ensure that the requested effective date is the same date as the form being received.