

INFORMATION CHANGE FORM



For Health.
For Wellness.
For Life.

If your requested change cannot be processed, you will be contacted by Physicians Health Choice.

MEMBER INFORMATION: As Physicians Health Choice currently has it on file.

Member Name: (First, Middle, Last) _____ **DOB:** _____ **Member ID:** _____ - 01

Physical Address: _____ **City/State:** _____ **Zip:** _____

TYPE OF CHANGE: Please indicate type of change requested along with new information.

ADDRESS CHANGE:

New Physical Address City: _____ State: _____ Zip: _____

New Mailing Address _____

PHONE NUMBER CHANGE:

Home: () - _____ Cell: () - _____ Other: () - _____

Emergency Contact Number: () - _____ Emergency Contact Name: _____

PRIMARY CARE PHYSICIAN (PCP) CHANGE: Your PCP change will take effect the 1st of next month. If your requested change cannot be processed, you will be contacted by Physicians Health Choice.

New PCP Name: _____

Member Signature: By signing below, I authorize the change requested above.

Personal Representative Information: A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at Physicians Health Choice or submitted with this form.

_____ (Print Name)	_____ (Printed Name of Personal Representative)	_____ (Description of Rep's Authority)
_____ (Signature of Member)	_____ (Signature of Personal Representative)	_____ (Phone Number)
_____ (Date)	_____ (Date)	

INTERNAL USE ONLY!

Data Entry Date: _____ **Proof Date:** _____ **Entered by (Initials):** _____