



PRIMARY CARE PHYSICIAN CHANGE FORM

Per your request, please complete this form and return it to Physicians Health Choice in the enclosed postage paid envelope by *<insert date>* for your change to take place the first of the month. Thank you for your prompt assistance regarding this important matter.

_____ *I would like to transfer to <insert medical group name> and select <insert physician name> as my new Primary Care Physician.*

**Please Sign and Complete the Following Information,
Then Return Form As Quickly As Possible in
The Enclosed Postage Paid Envelope:**

Member Name (print) _____

Member Signature _____ Date _____

PHC Member ID # _____

Name of Insurance Company _____

NOTE: Upon receipt of this change form, Physicians Health Choice will mail you a new member ID card with your choice of Primary Care Physician, the clinic location and phone number.

Si usted no entiende los contenidos de esta carta por favor llama a Servicios para los Miembros a y alguien la ayudara. 1-866-550-4736.