

PCP Change Request Form

Member Information		
First Name:		Middle Initial:
Last Name:		DOB:
Member ID #:		SSN:
Address:		Telephone #:
City:	State:	Zip:
PCP Change Request		
Requested PCP Name: CHING'S PEDIATRICS		NPI#: 1972079937
Office Address: 9260 W SUNSET RD STE 205		
City LAS VEGAS	State NV	Zip 89148
Office Telephone #: 702.982.3099		Tax ID #: 81-2897251
Effective Date:		
Reason for change from assigned PCP		
Please check (✓) appropriate response below:		
☐	New member made first time selection	☐ Provider location
☐	Already patient with requested PCP	☐ Association with hospital or medical group
☐	Requested PCP sees family members	☐ Language / communication barriers
☐	Member preference	☐ Wait time in provider office
☐	Member moved	☐ Appointment availability / access to care
☐	PCP hours did not fit member needs	☐ Established relationship with another PCP
☐	Quality of care	☐ Other

Signature of member or authorized representative

Date

Print name of member or authorized representative

Directions: please fax this form, with a copy of the member ID card, if available, to Member Services Department at **1-855-454-5578**. If you have questions about this form or want to make this request over the telephone, please call Member Services at **1-855-300-5528**. (TTY users dial **711**/TDD users dial **1-800-627-4702**).