



PHONE: 1-888-846-4262 FAX: 1-866-894-2036

# PCP CHANGE FORM

Head of Household Last Name:	First Name:	
Address:	Phone:	
City:	State:	Zip:

MEDICAID       MEDICARE

Member Name	ID Number	Old Primary Site	Old PCP	New Primary Site	New PCP

Note: 'Ohana Health Plan members may select a specialist, clinic or other provider as their PCP if the member has had a previous medical treatment by the specified provider and the specialist, clinic or other provider agrees, in writing, to assume the responsibilities of the PCP as stated on the 'Ohana Provider Manual.

### ATTESTATION

As the specialist, clinic or other medical provider for the member mentioned above, I have previously treated said person and agree to assume all responsibilities of a PCP for this patient as described in the 'Ohana Provider Manual.

PROVIDER NAME (PRINT) \_\_\_\_\_ PROVIDER TYPE: \_\_\_\_\_

Signature:	Date:
------------	-------

Please fax this form, when complete, to Member Services at: 1-866-894-2036.