



**PCP REQUEST FOR TRANSFER OF MEMBER**

Physician: \_\_\_\_\_ Member: \_\_\_\_\_  
ID#: \_\_\_\_\_ ID#: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_ Medicare  Medicaid

Please include detailed reason for request:

- Disruptive behavior     Non-compliance with treatment
- Missed appointment:    Date: \_\_\_\_\_    Date: \_\_\_\_\_    Date: \_\_\_\_\_
- Is this member on an active treatment plan?     Yes     No  
    If Yes, please provide brief description in space below.

Description:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please submit a copy of the progress notes from the member’s medical record that documents your concern.**

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:**

Complete this request in its entirety and attach all supporting documentation, including pertinent medical records and office notes. Providers are not allowed to communicate directly with Plan members regarding intent to transfer a member from their panel. After receiving adequate documentation and making an administrative ruling, the Plan will contact members regarding any changes in PCP assignments.

**Submit request to:**

**Member Services  
P.O. Box 31370  
Tampa, FL 33631-3370  
or Fax to Member Services at: (877) 297-3112**