

--- Please print clearly ---

**MEDICAID MANAGED CARE
PRIMARY CARE PHYSICIAN RE-ASSIGNMENT REQUEST**

FQHC INFORMATION

*Date of request (effective date of PCP change)	
*Name of FQHC making request	
*Name of FQHC staff member processing request	
*Telephone number of FQHC staff member	
*FQHC fax number	

MEMBER INFORMATION

*Date of service	
*Patient's full name	
*Patient's date of birth	
*Health Plan ID number	
*Name of Medicaid HMO	
*Medicaid ID Number	
*Member phone number	

PCP INFORMATION

Name of current PCP	
Managed Care Provider ID number of current PCP	
*Name of new FQHC PCP	
*Managed Care Provider ID or NPI of new FQHC PCP	
*FQHC location where member will be seen	

*** This form will not be processed unless these fields are completed**

TO BE COMPLETED BY PATIENT OR GUARDIAN:

- I am requesting that my primary care physician be changed to the new primary care physician listed above.
- I do not wish to change my primary care physician at this time.

SIGNATURE OF PATIENT: _____

- The new FQHC PCP must be credentialed with the Medicaid HMO.
- A copy of this completed form must be retained by the FQHC.
- The FQHC must ensure that this form is faxed to the correct HMO in accordance with the requirements of HIPAA.

Medicaid HMO	Fax number
Aetna Better Health of New Jersey	844.679.6853
AmeriGroup	866.840.4993
Horizon NJ Health	609.583.3004
UnitedHealthcare CommunityPlan	877-698-9679

Medicaid and NJ FamilyCare enrollees cannot be balanced billed by any Healthcare Provider. Signature or non-signature on this form has no financial impact on the enrollee. NJ FamilyCare enrollees are still responsible for their copayments.