

INFORMATION CHANGE FORM

If your requested change cannot be processed, you will be contacted by Physicians Health Choice.

MEMBER INFORMATION: As Physicians Health Choice currently has it on file.

Member Name: (First, Middle, Last) _____

DOB: _____

Member ID: _____

 Physical Address: _____

City/State: _____

 - 01
 Zip: _____

TYPE OF CHANGE: Please indicate type of change requested along with new information.

 ADDRESS CHANGE:
 New Physical Address

City:

State:

Zip

 New Mailing Address

 PHONE NUMBER CHANGE:

Home:

Cell:

Other:

Emergency

Contact Number:

Emergency

Contact Name:

 PRIMARY CARE PHYSICIAN (PCP) CHANGE: *Your PCP change will take effect the 1st of next month. If your requested change cannot be processed, you will be contacted by Physicians Health Choice.*

New PCP Name:

Member Signature: By signing below, I authorize the change requested above.

Personal Representative Information: A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at Physicians Health Choice or submitted with this form.

 (Print Name)

 (Printed Name of Personal Representative)

 (Description of Rep's Authority)

 (Signature of Member)

 (Signature of Personal Representative)

 (Phone Number)

 (Date)

 (Date)

INTERNAL USE ONLY!

Data Entry Date: _____ Proof Date: _____ Entered by (Initials): _____