

**Primary Care Provider (PCP)
Change Form**



Fax to: 410-840-7493

Please use this form to assign members to your practice.

Section 1 – Member Information		
Member Name:		Member ID:
Member Mailing Address:		
City:	State:	ZIP:
Member Phone:	DOB:	Date of Change:

Signature of Member/Legal Guardian: _____

Section 2 – Provider Information		
Group/Practice Name:		PCP Name:
TIN:	NPI:	
Practice Address:		
City:	State:	ZIP:
Phone:	Fax:	
Completed by:		

Member Services: 410-779-9369 / 800-730-8530