



1201 Winterson Rd.  
4th Floor  
Linthicum, MD 21090

## Primary Care Provider Change Form

\*\*\*\*\***Please Print**\*\*\*\*\*

**REQUIREMENT:** All fields must be completed in clarity to be processed, if not the requested PCP change will be omitted.

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member MA ID Number: \_\_\_\_\_

Member Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Member Phone #: \_\_\_\_\_

Member Signature: \_\_\_\_\_

**If member has a new address, please refer to Maryland Health Connections for an update**

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Provider's Name: \_\_\_\_\_

Site/Location: \_\_\_\_\_

Provider Tax ID Number: \_\_\_\_\_

Completed By: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_

**Please Note** – Provider's office must EVS member to obtain eligibility status and assigned MCO.

Fax form along with cover sheet to MPC Member Services Unit at 866-648-1012