WellCare Health Plans

PCP Change Request Form

Provider Instructions

Please complete only one form per member household. Forms completed improperly or missing the member or responsible party signature will not be processed, and primary care provider (PCP) change will not occur. Members can continue to be treated by the requested PCP until the change is completed. Members should continue to use their current WellCare ID card until they receive their new ID card. All requests will be processed within 7–10 business days of receipt. Provider Relations will be notified of incomplete and/or invalid form submissions. Please fax this form to: 1-855-247-7480

Part 1: Member Information (*Please print legibly.*) Please provide the member's information:

* Required Field

(Last Name) * _____ (First Name)* _____ (Middle Initial) _____

(WellCare Member ID #) * _____ (Member Phone # with Area Code)* _____ (Member Date of Birth)* _____/_____/_____

Part 2: PCP Change Request (*Please print legibly).* Please provide PCP information:

* Required Field

(Requested PCP Full Name) * _____ (WellCare Provider ID #)* _____

Part 3: Additional PCP Change Requests (*Please print legibly.*) Please provide other family members requesting change to same PCP:

Member Name:_____ Date of Birth_____ WellCare Member ID #: _____

Member Name:_____ Date of Birth_____ WellCare Member ID #: _____

Member Name:_____ Date of Birth_____ WellCare Member ID #: _____

Member Name:_____ Date of Birth_____ WellCare Member ID #: _____

Member Name:_____ Date of Birth_____ WellCare Member ID #: _____

Part 4: Reason for PCP Change Request

Please provide reason for the PCP change request (*Please check one of the boxes below.*):

- ☐ Different primary care provider preferred
- ☐ Referred by family/friend
- ☐ Convenient office location and/or hours
- ☐ Already a patient with requested PCP
- ☐ I requested this PCP upon enrollment, but WellCare assigned a different PCP on my WellCare ID Card.
- ☐ Dissatisfaction with assigned PCP: Note – WellCare will file a grievance on your behalf. You may receive a call requesting more information.
- ☐ Other: _____

Print Name of Member or Responsible Party _____ **Signature** of Member or Responsible Party _____

Provider (*Staff*) Signature _____ **Date** _____

Biological Parent? ☐ Yes ☐ No If "No," the name of the "Responsible Party" must match exactly what WellCare has on file for "Responsible Party." We cannot process this change without a match.

*Please call **1-877-389-9457** (TTY **1-877-247-6272**) if you have questions about this form.*

Note: The member needs to present their WellCare ID card to the requesting provider. PCP change requests received by the 10th of the month will be effective THAT month. PCP change requests received AFTER the 10th of the month will be effective the FOLLOWING month.