delaware first health

Primary Care Provider (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 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 ID card until they receive their new card. **Please fax this form, to Operations Response Team at (844) 743-1646.**

If you have any questions about how to complete this form or to make this request by phone, please call Delaware First Health Customer Service, Monday through Friday, 8am - 5pm (EST), at **(877) 236-1341** (TTY 711). A member can always choose a new PCP by calling the Member Services phone number on the back of the Member ID card.

Part 1: Member Information. Please add the member's information.		
First Name:	Last Name:	Date of Birth:
Member ID:	Member Phone # (with area code):	

Part 2: PCP Change Request. Please provide requested PCP information.	
PCP Full Name:	Practice Phone:
Practice/Group Name:	Practice Email Address:
NPI# (Rendering):	NPI# (Billing):
Practice/Group Address:	

Part 3: Additional Change Requests. Please provide other family members requesting change to same PCP.		
Member Full Name:	Date of Birth:	Member ID:
Member Full Name:	Date of Birth:	Member ID:
Member Full Name:	Date of Birth:	Member ID:
Member Full Name:	Date of Birth:	Member ID:
Member Full Name:	Date of Birth:	Member ID:

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Part 4: Reason for PCP Change Request.

☐ Referred by family/friend

☐ Convenient office location and/or hours

☐ Already a patient with requested PCP

☐ I requested this PCP upon enrollment with Delaware First Health, and was assigned a different PCP on my ID Card.

☐ Dissatisfaction with assigned PCP: Note—Delaware First Health will file a grievance on your behalf. You may receive a call requesting more information.

☐ Other: (Please Explain)

Part 5: Member or Guardian Signature

I request that the above-named provider be assigned as my/my child's PCP effective today.

Print Full Name of Member(s) Requesting PCP Change:	
Member or Guardian Signature	Date:

Part 6: Preparer Information

Provider/Staff Name and Title:	
Provider/Staff Signature:	Date:

PLEASE NOTE: PCP Changes are not retro-effective. PCP Change requests received AFTER the 1st of the month will be effective on the 1st of the following month.

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