Primary Care/ Main Doctor Detail

Name: ______________________________

Phone Number: ______________________________

Agree to take patient(s) listed below:

____

____

Primary Care Physician (PCP) / Main Doctor Change Form

FOR MEMBERS:

Do you want to change your main doctor? Here is what you can do:

- You may pick one main doctor or clinic for the whole family
- Each member may choose his/her own main doctor or clinic
- You must list each family member on this form even if you select the same main doctor or clinic.

Name: ______________________ **Cell Phone:** ____________ **Home Phone:** ____________

Address: __________________________ **City/State:** ________________ **Zip:** ____________

All items below MUST be filled out and faxed today | Fax to 209.461.2550

First Name	Last Name	CIN # or HPSJ/MVHP Member ID	DOB	Main Doctor or main Doctor's Clinic Name	Place/Address

New Member ID cards will be mailed to you **within 14 days** of choosing your new main doctor or clinic. Make sure to always carry your Health Plan of San Joaquin/Mountain Valley Health Plan (HPSJ/MVHP) ID card with you. **Have questions? Call 888.936.PLAN (7526) TTY/TDD 711**

FOR PROVIDERS:

Note: If the member has **not** accessed care from their assigned PCP during this month, the change can be made effective to the 1st of this month. If not, the PCP change will be made the 1st of next month.

Has any member listed above been seen by another PCP this month? Yes __ No __

Member facts: Existing Member: _____ New Patient: _____

Was member seen in the office today? Yes____ No ____

Reason for today's visit: ____

Member's signature: ________________________________ **Date:** ______________

Primary Care/ Main Doctor Detail

Name: ______________________________

Phone Number: __________________________

Agree to take patient(s) listed below:

____

____

Formulario de Cambio de Doctor Principal/Médico Primario

PARA MIEMBROS:

¿Desea cambiar de doctor principal? Puede hacer esto:

- Puede elegir un doctor o una clínica principal para toda la familia
- Cada miembro puede elegir su propio doctor o clínica principal
- Se debe incluir a cada miembro de la familia en este formulario, incluso si elige el mismo doctor o clínica principal para todos

Nombre: ________________ **Teléfono celular:** _________ **Teléfono de la casa:** __________

Dirección: ____________________ **Ciudad/estado:** _________ **Código postal:** __________

Nombre	Apellido	N.° de identificación de miembro de HPSJ/ MVHP de la tarjeta	Fecha de Nacimiento	Nombre del doctor o de la clínica principal	Lugar/ dirección

Le enviaremos las nuevas tarjetas de identificación de miembro dentro de los 14 días de haber elegido su nuevo doctor o clínica principal. Asegúrese de llevar siempre con usted la tarjeta de identificación de Health Plan of San Joaquin/Mountain Valley Health Plan (HPSJ/MVHP). **¿Tiene preguntas? Llame al 888.936.PLAN (7526) TTY/TDD 711**

Firma del Miembro: ______________________________________ **Fecha:** ______________

FOR PROVIDERS:

Note: If the member has **not** accessed care from their assigned PCP during this month, the change can be made effective to the 1st of this month. If not, the change will be made the 1st of next month.

Has any member listed above been seen by another PCP this month? Yes __ No __

Member facts: Existing Member: _____ New Patient: _____

Was member seen in the office today? Yes____ No ____

Reason for today's visit: ____