Request for a Change of
Primary Care Provider (PCP/AMH)
Fax to 1- 844-743-1646

Your primary care provider (PCP) is the main person who delivers your health care. Complete this form to change your PCP.

For urgent requests or immediate service, please contact your provider representative

Member Name:			
Member Date of Birth:	Member ID #:		
Member Street Address:	City:	State:	ZIP Code:
Member Phone #:	Current AMH Name:		

Reason for change (check one):

☐Member/PCP Relocation ☐PCP office inconvenient

☐Patient is already established ☐Member Choice

New AMH/ Practice Name:										New Individual Provider Name:										
New PCP NPI:											New AMH Tax ID:									
New AMH Street Address:										City:					State:				ZIP Code:	
Fax #:										Phone #:										

Member or Parent/Guardian Signature:	Date:

Signature of New PCP representative:	Date:

Please note: Effective date will be the 1st of the following month when received on or before the 16th of the month. Effective date will be the 1st of the month following the next month if received after the 16th day of month or later.

Members may be seen by their chosen PCP before they receive their new ID card.

Language Assistance