



**CeltiCare Health Plan of Massachusetts, Inc.
PCP Change Request Form**

Member Information

Full Name: _____
Last _____ *First* _____ *M.I.* _____
Member ID: _____
Social Security Number or Government ID: _____
Birth Date: _____
Contact Phone Number: () _____

PCP Change Request

Please Provide PCP Information

Requested PCP Name: _____ Provider ID: _____
Office Address: _____
City: _____ Zip Code: _____
Office Phone: () _____
Effective Date: _____

Reason for Change from Assigned PCP

- | | |
|---|--|
| <input type="checkbox"/> Already patient with requested PCP | <input type="checkbox"/> Office wait time too long for assigned PCP |
| <input type="checkbox"/> Requested PCP already sees family member | <input type="checkbox"/> Appointment wait time too long for assigned PCP |
| <input type="checkbox"/> Assigned PCP is too far | <input type="checkbox"/> Assigned PCP is not accepting new patients |
| <input type="checkbox"/> Other | |

Signature of Member or Authorized Representative

Date

Printed Name of Authorized Representative

Directions: Please fax Member Change Data forms, with a copy of the member ID card, if available, to CeltiCare Member Services Department at (617)787-1497, or mail it to CeltiCare Member Services, 1380 Soldier's Field Road, Suite 300, Brighton MA, 02135.

If you have questions about how to complete this form, please call the CeltiCare Member Services Department, Monday through Friday, 8AM-5PM, at (866)895-1786.