

Primary Care Provider (PCP) Change Request Form

I, _____, (Member Name) would like to change my PCP to:

Provider Name: _	
Provider Address: _	
Provider Phone Number: _	
Provider TIN: _	
Provider NPI: _	

I understand that as an Iowa Total Care member, I have the right to request a change to my assigned PCP at any time.

Date:	
Member Phone Number:	
Iowa Total Care Member ID:	
Member (or legal guardian) Signature:	

If you have any questions or need assistance with changing your PCP, please call **Iowa Total Care Member Services at the number on the back of your Iowa Total Care ID card.**

Please fax this completed form to 833-847-3026.