Change Primary Care Provider
Request Form

Please fill out and fax to: 888-205-9851

PLEASE PRINT

Member ID ____ Date of birth (month/day/year) ____

Member Name: First ____ MI ____ Last ____

Address ____

City ____ State ____ Zip ____

Phone number ____ Signature ____

ID card will be mailed to the last reported address at TennCare. If you have recently moved, please contact the Family Assistance Service Center at 866-311-4287.

This information must be filled out or change request will not be done.

Is your provider panel open to new TennCare patients ___Yes ___No

If Provider Panel is closed please indicate reason for adding the patient to closed panel. ____

New Primary Care Provider ____

Address ____

City ____ State ____ Zip ____

Phone number ____ Fax number ____

Nine digit TAX ID# ____ Two digit suffix: ____

Physician signature ____ Date ____

Please fax only this page to the number above.

8 Cadillac Drive, Suite 100, Brentwood, TN 37027
800-690-1606 UHCCommunityPlan.com

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