Primary Care Provider (PCP) Selection/Change Form

Please complete this form if the PCP on your Molina Healthcare ID card is incorrect.
We are unable to process your request unless this form is complete.

New Provider Information (please print)

PCP Name _____ Clinic _____

PCP Address _____

City _____ Zip _____ PCP Phone # _____

Have you seen this provider in the last year? ☐ YES ☐ NO

Member Information (please print)

Member Full Name _____ Phone #_____

Date of Birth ____ /____ /____ Molina Healthcare ID # __ __ __ __ __ __ __ __ __ __ __ __

Member Full Name _____

Date of Birth ____ /____ /____ Molina Healthcare ID # __ __ __ __ __ __ __ __ __ __ __ __

Member Full Name _____

Date of Birth ____ /____ /____ Molina Healthcare ID # __ __ __ __ __ __ __ __ __ __ __ __

Member Full Name _____

Date of Birth ____ /____ /____ Molina Healthcare ID # __ __ __ __ __ __ __ __ __ __ __ __

Member Full Name _____

Date of Birth ____ /____ /____ Molina Healthcare ID # __ __ __ __ __ __ __ __ __ __ __ __

Member Full Name _____

Date of Birth ____ /____ /____ Molina Healthcare ID # __ __ __ __ __ __ __ __ __ __ __ __

Signature of Member or Member's Guardian ***Today's Date***

Guardian's Full Name (please print)

This change will be effective the 1st of the next month. You will receive your new ID card(s) within 7-10 business days once the form has been processed. If you need this change right away, please contact Molina Healthcare of Washington Member Services before the 15th of the month at (800) 869-7165 Monday through Friday, 8:00 a.m. – 5:00 p.m.

MRC Part# 11-818
Approvals: MHW – 8/22/11 HCA (BH) – 8/24/11 HCA (HO) – 8/31/11

Mail completed form to: PO Box 4004 Bothell, WA 98041-4004 **or**
Fax completed form to: (800) 816-3778