



# Provider Request to Change Primary Care Provider

Medicaid (Healthy MI and CSHCS)  Molina Dual Options (MI Health Link)  Marketplace  Medicare (D-SNP)

Member's Name: \_\_\_\_\_ Member's Molina ID #: \_\_\_\_\_  
Please print FIRST and LAST name Date of Birth: \_\_\_\_\_

## Additional Family Molina Members

Member's Name: \_\_\_\_\_ Member's Molina ID #: \_\_\_\_\_  
Please print FIRST and LAST name

Member's Name: \_\_\_\_\_ Member's Molina ID #: \_\_\_\_\_  
Please print FIRST and LAST name

Member's Address: \_\_\_\_\_  
(Please print)  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Member's Phone: (\_\_\_\_) \_\_\_\_\_ Cell or Alt. #: (\_\_\_\_) \_\_\_\_\_

My Molina ID card currently has my Primary Care Provider listed as: \_\_\_\_\_  
Please print provider's name

I would like to change my Primary Care Provider to: \_\_\_\_\_  
Please print NEW provider's name

NEW Provider's Address: \_\_\_\_\_  
(Please print)  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

NEW Provider's Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Signature of Member or Delegated Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Print FIRST and Last Name

\_\_\_\_\_  
Date

Email to:  
[MHMPROVIDERPCP.CHANGEREQUEST@MolinaHealthCare.Com](mailto:MHMPROVIDERPCP.CHANGEREQUEST@MolinaHealthCare.Com)  
To make an immediate change while with your patient,  
please call toll-free at (855) 322-4077

Mail to: Molina Healthcare of Michigan, Inc.  
Provider Services  
880 West Long Lake Rd #600  
Troy, MI 48098