



Request to Change Primary Care Provider

MississippiCAN (Medicaid)

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

Mail to:

ATTN: Member Services
Molina Healthcare of Mississippi
1020 Highland Colony Parkway, Suite 602
Ridgeland, MS 39157