# Request to Change Primary Care Provider

Member's Name: _____ Member's Molina ID #: _____
(Please print FIRST and LAST name.)

Member's Address: _____
(Please print.)
City: _____ State: _____ ZIP: _____

Member's Phone: (_____)_____ Alt. Phone: (_____) _____

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 completed form to:**
**MemberServicesOnline@MolinaHealthCare.Com**

**If you have any questions, please call Member Services:**
HealthChoice Illinois: **(855) 687-7861**
Hearing Impaired/TTY: 711

**Or mail to:** Molina Healthcare of Illinois
Member Services Department
1520 Kensington Road, Suite 212
Oak Brook, IL 60523