Request to Change Primary Care Provider

☐ **Medicaid** (Healthy MI and CSHS) ☐ **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*

Fax completed form to: (810) 275-9264
Email to:
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
1321 S. Linden Road
Flint, MI 48532