MOLINA HEALTHCARE
Your Extended Family.

Healthy Connections

Request to Change Primary Care Provider

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

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

Practice Name: _____ Group NPI: _____

NEW Provider's Address: _____
Please print

City: _____ State: _____ ZIP: _____

NEW Provider's Phone: (_____)_____ NEW Provider's Fax: (_____)_____

_____ _____
Signature of Member or Delegated Guardian *Relationship*

_____ _____
Print FIRST and LAST Name *Date*

Fax completed form to: (844) 834-2155

If you have any questions, please call toll-free:
Member Services: (855) 882-3901
Hearing Impaired/TTY: 711

Or mail to: Molina Healthcare of South Carolina
Member Services Department
PO Box 40309
North Charleston, SC 29423-0309

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