healthfirst

Please Fill Out All Fields

Fax To: 1-212-497-8998

Request Primary Care Physician (PCP) Change

From: HICKSVILLE FAMILY MEDICAL CARE PLLC Date: _____

MemberInfo

First Name: _____ Last Name: _____

Healthfirst ID Number: _____ Preferred Contact Number: _____

Current PCP On Member ID Card: _____

Current PCP's Healthfirst ID Number: _____

Change PCP to: _____

Reason ~~for~~ Change: WANTED TO CHANGE PCP

Healthfirst Provider ID Number: _____ Effective Date of Change*: _____

*Back dating is acceptable under the following circumstances (please select one):

- ☐ Member is newly effective with no PCP assigned.
- ☐ Member visited a new PCP on the weekend, a holiday, or after hours when Healthfirst was closed.
- ☐ Member is a newly effective newborn or member and was assigned the wrong PCP.
- ☐ Other (please explain): _____

_____

_____

Member Or Legal Guardian Signature: _____

By signing this form I am giving my healthcare provider permission to give this information to Healthfirst.

Date Signed: _____

NOTE: ID cards will be mailed to the members address on file with Healthfirst.

Fax Transmittal