



## Primary Care Physician Change Request Form

(To be completed and submitted by the physician with the patient's consent)

(Please print clearly and complete ALL fields.)

Your primary care physician is the doctor you go to first and most often for your health care needs and for guidance about important preventive care to keep you healthy and active. By signing this form, you are selecting a new primary care physician and notifying Humana to make this change to its files.

### Option for member to self-select primary care physician by phone

You also can select a different doctor as your primary care physician by calling Humana at the number found on the back of your ID card.

### Option for member to select primary care physician in physician's office

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Humana member ID: \_\_\_\_\_ Phone number: \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Current primary care physician

Name: \_\_\_\_\_ Group/location: \_\_\_\_\_

#### New primary care physician

Full name: \_\_\_\_\_ Group/location: Hicksville Family Medical Care PLLC

Tax ID: 27-1058844 Address: 232 W Old Country Rd, Hicksville, NY 11801

Effective date of change: \_\_\_\_\_ Vendor/center number (if known): \_\_\_\_\_

Reason for change: Wanted to change PCP.

Preparer name: Jacob Andre Dela Cruz Date: \_\_\_\_\_

Preparer signature: \_\_\_\_\_ Phone number: (850) 790-9546

### Submit the form

Please submit the completed form to Humana by fax at **1-800-633-8188** or by mail to Humana, P.O. Box 14168, Lexington, KY 40512-4168.

**NOTE: All change requests are subject to verification and physician availability.**

