Patient Record #: ______________

PCP CHANGE REQUEST FORM*

Today's Date:	
From (Staff Member Name & Location):	
Staff Contact Number:	
Patient's Full Name:	
Patient's Date of Birth:	
Patient's Contact Number:	
Patient's Insurance (if applicable):**	
Name of Current QHC Site:	
Name of Current PCP:	
Name of Requested QHC Site:	
Name of Requested PCP:	
Reason for Request:	☐ Change of residence ☐ Gender of provider ☐ Language preference ☐ Other: ______________________________
Signature of Patient or Legal Representative:	
If Legal Representative, Print Name:	

*The requested change(s) will be effective as of the first of the following month.
**All requests for patients *with* insurance/covered by a health plan should be processed in the health center by the patient directly with the insurance co./health plan; form should be scanned into patient's EHR and forwarded to the CMO/Dental Director. Requests for patients *without* insurance should be faxed to: (323) 953-3658, Attn: Quality Assurance Manager or forwarded via Interoffice Mail to the QA Manager (Suite 508/Doctors' Tower).

FOR ADMINISTRATIVE USE ONLY	
NAME OF STAFF MEMBER PROCESSING REQUEST:	
DATE PROCESSED:	
EFFECTIVE DATE:	
DATE PATIENT WAS NOTIFIED:	

If you have questions, please contact the
Quality Assurance Manager at (323) 669-4326 or the Call Center at (800) 454-1800.

Rev Sept 2013