Change Form

PriorityHealth

Priority Health • PO Box 205 • Grand Rapids, MI 49501-0205
(Member changes must be received by Priority Health within 31 days of the event.) Fax to 616 942-5242

Employee Information

Employee's Last Name	First Name	Middle Initial	Social Security Number
			— —

Changes (Please complete only those changes which apply.)

☐ ADDRESS/PHONE CHANGE	Street Address		City
State	Zip Code	Home Phone ( ) -	Work Phone ( ) -

☐ NAME CHANGE	New Last Name	Former Last Name

☐ **DEPENDENT CHANGE** **(If you have more than 4 dependent changes please complete an additional change form).** Date Change Occurred / / Reason for Change Add ☐ Delete ☐

1	Last Name	First Name	Middle Initial	Social Security Number — —
	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes ☐ No ☐		PCP Address/ID Code	
2	Last Name	First Name	Middle Initial	Social Security Number — —
	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes ☐ No ☐		PCP Address/ID Code	
3	Last Name	First Name	Middle Initial	Social Security Number — —
	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes ☐ No ☐		PCP Address/ID Code	
4	Last Name	First Name	Middle Initial	Social Security Number — —
	Birth Date / /	Sex Male ☐ Female ☐	Relation to Employee	Primary Care Provider (REQUIRED for HMO & POS)
	Has this dependent ever seen this provider? Yes ☐ No ☐		PCP Address/ID Code	

Authorization

I authorize Priority Health to make the changes indicated above for me and my dependents. I understand that Priority Health may request pertinent sworn statements if needed and that I must sign and date this form before it will be processed.

Priority Health requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request.

X _____
Employee Signature Date

	Employer Name	Group Number	Sub Group Number	Class
	Employer/Representative Signature			Date / /
	Plan Change ☐ (If checked, please also check one of the following) HMO ☐ POS ☐ PPO ☐ HBC ☐ HRA ☐ HSA ☐ Plan Option (if applicable) High ☐ Mid ☐ Low ☐			
	REASONS FOR ADDITIONS Marriage ☐ Birth ☐ Adoption ☐ Divorce ☐ Death ☐ Lost Eligibility ☐ Loss of other coverage (Proof Required) ☐ Other ☐ _____			Effective Date / /
	REASONS FOR DEPENDENT TERMINATION Marriage of Dependent ☐ Divorce ☐ Death ☐ Lost Eligibility ☐ Other ☐ _____		Date participant notified of coverage termination / /	Date Coverage Ended / /
	REASON FOR TERMINATION OF ENTIRE CONTRACT Terminated Employment ☐ Lay Off ☐ Leave of Absence ☐ Changed Health Plans ☐ Moved out of area ☐ Death ☐ COBRA Terminated ☐ Dissatisfied ☐ Other ☐ _____		Date participant notified of coverage termination / /	Date Coverage Ended / /

For Priority Health Use Only	Date Received / /	Processor	Code	Date Processed

In accordance with the Genetic Information Nondiscrimination Act (GINA) of 2008, Priority Health requests that you not include any genetic information on this form. Genetic information includes any genetic testing results of either yourself or a family member, your family health history or any requests for or receipt of genetic services.

Primary care provider change form

PriorityHealth®

Please complete this form to change your primary care provider (PCP). Or call us at the number on the back of your ID card to change your PCP or get your questions answered. Fax completed forms to 616 942-5242 or mail to: Priority Health, PO Box 205, Grand Rapids, MI 49501-0205.

Section 1 - Member information

Member last name	First name	Middle initial	Social Security Number — —
Employer name		Group number (found on your ID card)	

Section 2 - New primary care provider

This change becomes effective the first of the month following the date we get your request.

Member/dependent name	Priority Health PCP	PCP address	Are you or your dependent a current patient?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Reason for change

- ☐ I've moved
- ☐ PCP moved
- ☐ PCP left practice
- ☐ Office location is hard to get to
- ☐ PCP no longer with Priority Health
- ☐ Did not want PCP I was assigned
- ☐ Personal preference
- ☐ Communication problems with PCP/office staff
- ☐ Hard time getting appointments
- ☐ Wait time in the office too long
- ☐ Not satisfied with the office staff
- ☐ PCP/office staff rude or annoying
- ☐ Poor quality of medical care

Section 3 - Authorization for primary care provider change

I authorize Priority Health to make the changes indicated above for me and my dependents.
I understand that I must sign and date this form before it will be processed.
Priority Health requires proper handling of personal health information for our members.
Details of our confidentiality policies and procedures are available upon request.

☐ Parent of a minor child ☐ Legal guardian
☐ Power of attorney

Signature	Date ____/____/____

For Priority Health Use Only	Date received	Processor	Code	Date processed
	Effective date			

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