Amerigroup Primary Care Provider Reassignment Request Form

Your primary care provider (PCP) is the main person who gives you health care. Complete this form to change your PCP.

For urgent requests, please call Member Services using the number on the back of the Member ID card.

Member Information

Member's Full Name	
Member's Date of Birth	
Legal Guardian's Name (if younger than age 18)	
Amerigroup ID Card Number	
State of Residence	
Medicare ID Card Number	
Patient Phone Number	

PCP Information

Date of Request (Effective Date of PCP Change)	
Name of New PCP	
Name of New PCP Staff Member Processing Request (if applicable)	
Telephone Number of New PCP	
New Provider NPI Number (if available)	
New Provider Address	

To Be Completed By Patient or Guardian

☐ I am requesting that my PCP/my child's PCP be changed to the name listed above.

Signature of Patient/Responsible Party: _____

Signature of New PCP (not required): _____

Reason for Reassignment:

☐ Auto-assign/choice issue ☐ Member/PCP relocation ☐ PCP office inconvenient

☐ Unhappy with PCP ☐ Appointment availability ☐ Other/no reason

Please give us more detail: _____

ALLOW 24-72 HOURS FOR PROCESSING.
FORMS WILL NOT BE PROCESSED UNLESS ALL FIELDS ARE COMPLETED.

EMAIL PCP REQUESTS TO:
MedicareAdvantageAssistance@anthem.com