Primary Care Physician (PCP) Form

ONE MEMBER PER FORM

KanCare

sunflower health plan

Member information *Required field

First name: MI: Last name:

Medicaid ID*: Date of birth (mmddyyyy):

SSN: Telephone number: - -

Mailing address:

City: State: Zip code:

PCP change request — Please provide PCP Information

Requested PCP name NPI#

Office address:

City: State: Zip code:

Office phone: - - Effective date (mmddyyyy):

The effective date will be based upon the plan's selection/change policy.

Reason for change from assigned PCP — Choose all that apply. Select at least one.

- ☐ New member — made first-time selection
- ☐ Already patient with requested PCP
- ☐ Requested PCP already sees family member
- ☐ Member preference
- ☐ Member moved
- ☐ PCP hours didn't fit member need
- ☐ Quality of care
- ☐ Provider left network
- ☐ Provider location
- ☐ Association with hospital or medical group
- ☐ Language/communication barriers
- ☐ Wait time in provider office
- ☐ Availability to get appointment; access to care
- ☐ Established relationship w/another
- ☐ Provider request to disenroll member
- ☐ Other

_____

Signature of member or authorized representative

Date (mmddyyyy)

_____

Print name of member or authorized representative

Directions: Please fax Member Change Data forms, with a copy of the member ID card, if available, to Sunflower Health Plan Customer Service at **866-491-1824** or mail it to Sunflower Customer Service, 8325 Lenexa Dr., Suite 410, Lenexa, KS 66214. If you have questions about how to complete this form or want to make this request over the phone, please call Customer Service from 8 a.m. to 5 p.m. (CT), Monday through Friday, at **877-644-4623** (TTY 711).