



You can have this in large print, another language, or any way that works for you. You can have a language interpreter if you need one. Please call us at 541-229-4UHA (541-229-4842).

## Primary Care Physician Change Request Form

To Physician: With the patient’s consent, please fill out the entire form, ask your patient or their representative to sign it, and send it to UHA. We will not process incomplete or unsigned forms. Incomplete forms will be returned (if possible). Assignment requests must be for PCPs in UHA’s network.

### Important

- Any prior approvals may no longer be valid with the new PCP.
- If the member goes into the hospital before the change takes effect, the member will remain with the existing PCP until the episode of care is complete.
- If a mother requests a PCP assignment for her newborn, we will process the request or change after the baby has an Oregon Health ID card.
- Most changes will take effect the date UHA receives this form.

### Option for member to self-select PCP by phone

You also can change to a different PCP by calling Umpqua Health Alliance Member Services at 541-229-4842. We are open Monday – Friday 8:00 am – 5:00 pm.

### Option for member to select PCP in physician’s office

**Please fill out all sections highlighted in BLUE**

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

UHA member ID: \_\_\_\_\_ Phone number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Member or authorized representative*



**Current PCP (if any)**

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

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

- Already patient with requested PCP
- Quality of care
- Availability to get appointment, access to care
- Language / Communication barriers / Cultural Considerations
- ADA Accessibility
- Provider Location
- Member preference

**This section is for Providers Office only**

**New PCP**

Requesting PCP Name: \_\_\_\_\_

NPI: \_\_\_\_\_ Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_

Preparer name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Preparer signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Submit the form**

Please submit the completed form to UHA by fax at 541-677-6038, or by mail to Umpqua Health Alliance 500 SE Cass St, Suite 101, Roseburg OR 97470.