

# PRIMARY CARE PHYSICIAN CHANGE REQUEST FORM

**THIS FORM IS FOR EXTERNAL PCP CHANGES ONLY** (from one office to another).

If you would like to make an internal PCP change (to another provider within the same office), please contact UHA Customer Care at 541-229-4842.

## Use this form to:

- Change a patient's PCP to a provider within their clinic
- Allow a member to self-select their PCP in-office

## Before filling out this form, please know:

- Changes will take effect on the date the member signs this form.
- 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 parent/guardian requests a PCP assignment for their newborn, we will process the request or change after the baby has an Oregon Health ID card.

## Instructions for PCP's:

- Providers, with your patient's consent, please fill out the entire form.
- After you fill out the form, ask your patient, or their representative to sign it, and then you will need to 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.

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## OPTION FOR MEMBER TO SELF-SELECT PCP BY PHONE

To change to a different PCP by phone, call Umpqua Health Alliance Customer Care at 541-229-4842. UHA Customer Care is open Monday through Friday from 8:00 am – 5:00 pm.

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## Use one of the following options to submit this form:

- Fax: 541-677-6038
- Email: [UHCustomerCare@umpquahealth.com](mailto:UHCustomerCare@umpquahealth.com)
- Mail: 3031 NE Stephens St.  
Attn: UHA Customer Care  
Roseburg, OR 97471

**MEMBER INFORMATION:**

Make sure the member, or their authorized representative, signs this form before you submit. Unsigned forms will not be processed.

Patient Name		Date of Birth	
UHA Member ID		Phone Number	
Mailing Address			
Signature		Date	

Current PCP Name in CIM (if any)		Group/Location	
Reason for change from assigned PCP. Select at least one, choose all that apply.			
<input type="checkbox"/> Already patient with requested PCP <input type="checkbox"/> Availability to get appointment, access to care <input type="checkbox"/> ADA Accessibility <input type="checkbox"/> Member preference <input type="checkbox"/> Quality of Care <input type="checkbox"/> Language/ Communication barriers/ Cultural Considerations <input type="checkbox"/> Provider location			

**PROVIDER INFORMATION:**

Remember, this form is for EXTERNAL PCP changes only.

Requesting PCP Name			
NPI		Tax ID	
Address			
Preparer Name		Phone Number	
Preparer Signature		Date	