Primary Care Provider (PCP) selection/change form

Please print clearly and complete all applicable fields with the assistance of your provider's office.

PROVIDER INFORMATION		
Practice name		Today's date (MM/DD/YYYY)
Primary Care Provider (PCP) name		
Pay to/group number		PCP NPI number
Practice street address		
City	State	ZIP
Practice phone number	Practice fax	
Completed by: (Print name)		

MEMBER INFORMATION: PLEASE PRINT CLEARLY. *Complete all applicable fields with the assistance of your provider's office.*		
Member name		
Member identification number	Birth date (MM/DD/YYYY)	
Member mailing street address		
City	State	ZIP
Member phone number	Member alternate phone number	

I certify that the information on this PCP selection/change form is true and correct to the best of my knowledge.

_____ _____

Member's signature Date

_____ _____

Parent or legal guardian signature Date
(For members under 18 years old)

PROVIDER, PLEASE SEND COMPLETED FORM:		
By mail: Fallon Health **Attention: Enrollment Department** Enrollment and Billing Operations 1 Mercantile St., Ste. 400, Worcester, MA 01608	**By email:** PCPatFCHP@fallonhealth.org	**By fax:** 1-508-831-1136

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