ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

SELECTIONS:

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1. _____
   PHYSICIAN NAME

2. _____
   PHYSICIAN NAME

3. _____
   PHYSICIAN NAME

CHANGES:

I want to change my primary care physician because:

_____

_____

_____

_____

_____

_____

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_____
BENEFICIARY SIGNATURE

_____
MEDICAID I.D. NUMBER

_____
DATE

DMS-2609 (Rev. 4/07)