

**ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM
PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM**

Member Information:

First Name _____ Last Name _____ Middle Initial _____
Medicaid ID# _____ Social Security # _____
Birth Date (mm/dd/yyyy) _____
Mailing Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____
Email address _____

Requested New Doctor (Primary Care Provider):

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. | _____ | _____ | _____ |
| | Doctors first and last name | Medicaid Provider ID# | Date of assignment |
| 2. | _____ | _____ | _____ |
| | Doctors first and last name | Medicaid Provider ID# | Date of assignment |
| 3. | _____ | _____ | _____ |
| | Doctors first and last name | Medicaid Provider ID# | Date of assignment |

**Reason for Request to Assign/Change Doctor (Primary Care Provider)
Choose all that apply. Select at least one.**

- New Member – made 1st 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
- Office wait times are too long
- Takes too long to get an appointment
- Office too far away/ hard to get to
- Language / communication barrier
- Other (please specify) _____

Signatures:

Member Signature (or Legal Guardian if a minor) _____
Printed Name of Member (or Legal Guardian if a minor) _____
Date (mm/dd/yyyy) _____