TRUSTED HEALTH PLAN/ALLIANCE PROGRAM MEMBER PCP DESIGNATION FORM

I, _____ am a patient who agrees to be seen for
(Member Name)
Medical services at the following clinic/provider office:

_____

I have been assigned to Trusted Health Plan and my Member ID number is:

_____

I would like _____ to be my Primary Care Provider (PCP), effective: _____.

I, _____ as the member, understand that by requesting this PCP assignment that I will continue to seek and receive care from my PCP until I officially request a PCP change by contacting the health plan indicated above. This change will result with a new member card being issued.

Please complete the contact information below to ensure that your card is mailed to your current residence or if homeless, clinic where services are obtained.

_____ _____
Print Member Name Date of Birth

_____ _____
Member Signature Date of Signature

_____
Member Home Address: House Number, Street Name and Apt # (If applicable)

_____ _____ _____ _____
City State Zip Telephone #

_____ _____ _____ _____
Witness Signature Witness Name Name & Telephone # Date

Please fax the form to:
Trusted Health Plan
Attn: Enrollment
202-821-1098

Clinic/Provider Office

Please fax the form to:
Trusted Health Plan
Attn: Enrollment
202-821-1098