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) _____