

**Preferred Care Primary Care (PCP) & OBGYN Change Form**

Member's Name: \_\_\_\_\_

Member's Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Member #: \_\_\_\_\_

DOB: \_\_\_\_\_

**PCP Change**

Name of current PCP: \_\_\_\_\_

Name of new PCP: \_\_\_\_\_

Address of new PCP: \_\_\_\_\_

Effective date of change: \_\_\_\_\_

Member's (or Parent's) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please fax completed forms to Preferred Care's Member Service Department at:  
(585) 327-2298