PCP Change Request Form

Member Information

Please Note: This form must be completed and signed by the member/guardian

ID Number	
First Name	
Last Name	
Date of Birth	
Street Address	
City	
State	
Zip	
Telephone	
PCP Name Currently Listed on Member Card	
Name of New PCP Requested	
Printed Name of Member or Guardian **(Required)**	
Signature of Member or Guardian **(Required)**	
Relationship to Member	
Date of Request	

Note: The PCP change will be made effective the first day of the following month from the date of request as indicated above.

Fax to: Member Services 804-819-5188

Mail to:
Virginia Premier Health Plan, Inc.
Attention: Member Services
P.O. Box 5307
Richmond, Virginia 23220