MEMORIAL HERMANN Health Plan

MEMORIAL HERMANN *ADVANTAGE* HMO

Member PCP Change Request Form

Please Email to: **MHHP_PCP_Change@apex.4health.com**

MEMBER INFORMATION		
First Name	**Last Name**	**Middle Initial**
Mailing Address		**Phone #**
City	**State**	**Zip**
Date of Birth	**Member ID #**	

PCP Name	**PCP ID # (Optional)**	
PCP Address		**PCP Phone #**
PCP City	**PCP State**	**PCP Zip**
Reason for PCP Change ☐ Other:	☐ Already Patient with PCP ☐ Provider Left Network	☐ Network Access ☐ Quality of Care Concerns

Member agrees and willingly selects new PCP.

Print name of Member or Responsible Party: _____

Signature of Member or Responsible Party: _____ Date: _____

Provider Staff Assisting Member: _____ Provider Staff Phone: _____

Memorial Hermann *Advantage* HMO is provided by Memorial Hermann Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in this plan depends on contract renewal.

Memorial Hermann *Advantage* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.645.8448 (TTY 711).