**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.

| | Doctors first and last name | Medicaid Provider ID# | Date of assignment |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

**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) _____