Please Fill Out All Fields
Fax To: 1-212-497-8998

From: ____________________________ Date: ____________________________

Member Info

First Name: ____________________________ Last Name: ____________________________

Healthfirst ID Number: ____________________________ Preferred Contact Number: ____________________________

Current PCP On Member ID Card: ____________________________

Current PCP’s Healthfirst ID Number: ____________________________

Change PCP to: ____________________________

Reason for Change: ____________________________

Healthfirst Provider ID Number: ____________________________ Effective Date of Change*: ____________________________

*Back dating is acceptable under the following circumstances (please select one):

☐ Member is newly effective with no PCP assigned.

☐ Member visited a new PCP on the weekend, a holiday, or after hours when Healthfirst was closed.

☐ Member is a newly effective newborn or member and was assigned the wrong PCP.

☐ Other (please explain): ____________________________

Member Or Legal Guardian Signature: ____________________________

By signing this form I am giving my healthcare provider permission to give this information to Healthfirst.

Date Signed: ____________________________

NOTE: ID cards will be mailed to the members address on file with Healthfirst.

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