
PCP REQUEST FOR TRANSFER OF MEMBER

Physician: _____ Member: _____
ID#: _____ ID#: _____
Telephone: _____ Telephone: _____
Fax: _____ Medicare Medicaid

Please include detailed reason for request:

- Disruptive behavior Non-compliance with treatment
 Missed appointment: Date: _____ Date: _____ Date: _____
 Is this member on an active treatment plan? Yes No
 If Yes, please provide brief description in space below.

Description:

Please submit a copy of the progress notes from the member's medical record that documents your concern.

Physician signature: _____ Date: _____

Instructions:

Complete this request in its entirety and attach all supporting documentation, including pertinent medical records and office notes. Providers are not allowed to communicate directly with Plan members regarding intent to transfer a member from their panel. After receiving adequate documentation and making an administrative ruling, the Plan will contact members regarding any changes in PCP assignments.

Submit request to:

**Member Services
P.O. Box 31370
Tampa, FL 33631-3370
or Fax to Member Services at: (877) 297-3112**