Request to Change Primary Care Provider

Member's Name: _____ Member's Molina ID #: _____
Please print FIRST and LAST name.

Member's Address: _____
(Please print.)

City: _____ State: _____ ZIP: _____

Member's Phone: (_____) _____ Cell or Alt. #: (_____) _____

My Molina ID card currently has my Primary Care Provider listed as: _____
Please print provider's name.

I would like to change my Primary Care Provider to: _____
Please print NEW provider's name.

NEW Provider's Address: _____
(Please print.)

City: _____ State: _____ ZIP: _____

NEW Provider's Phone: (_____)_____

_____ _____
Signature of Member or Delegated Guardian Relationship

_____ _____
Print FIRST and Last Name Date

Fax this completed form to: (844) 834-2155

If you have any questions, please call Member Services:
HealthChoice Illinois: (855) 687-7861
Hearing Impaired/TTY: 711

Molina Healthcare of Illinois
Member Services Department
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515