Provider Request to Change PCP on Behalf of Member (Transfer into My Practice)

☐ **Medicaid** (Healthy MI and CSHCS) ☐ **Molina Dual Options** (MI Health Link) ☐ **Marketplace** ☐ **Medicare**

Member's Name: ________________________________ Member's Molina ID #: ____________________

Please print FIRST and LAST name

Date of Birth: ______________________________

Additional Family Molina Members

Member's Name: ________________________________ Member's Molina ID #: ____________________

Please print FIRST and LAST name

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*

Submit your request to:
Molina Healthcare of Michigan, Inc.
Email: MHMPROVIDERPCP.CHANGEREQUEST@MOLINAHEALTHCARE.COM
-or-
You may fax the completed form and documentation to (844) 834-2155

NOTE-This request may take up to 45 days to process.