Primary Care Site Change Request Form

All applicable fields are required. Fax completed form to **617-526-1985.**

Member Information

Member Name: ________________________Member ID #: ____________________Member DOB: ___________

Address: _______________________________________ City: ___________________________ Zip: __________

Parent/Guardian Name: ____
(If age of member requires parent/guardian name*)

Address: ____ Phone: ______________________

*Member or Parent/Guardian Signature ____

Site Information

Change from: Current Site Name: ____________________________Current PCP: ______________________

Change to: New Site Name:____ NPI:_____________________

New Site Address: ________________________________ City: ________________________ Zip: ____________

New PCP: ____ NPI: _____________________

**Effective Date of Change: ______________ Reason for Change_______________________________________

*Forms not bearing the member's signature cannot be processed.
**Unless otherwise specified date will be the first of the following month. Exceptions are subject to NHP's approval.

Member re-assignments to PCPs practicing *within the same site* must be processed via NHPNet. For assistance with NHPNet registration, please contact your Provider Relations Representative directly or email Provider Relations at prweb@nhp.org.

Site Contact Information

Name: ____ Phone: _________________________

Signature: ____ Date: ___________________________

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