of Tennessee

MEDICARE ADVANTAGE

Primary Care Provider (PCP) Change Request Form

Note: Please provide all required information to help ensure timely processing.

Member Information Date Submitted: _____ /_____ / 20 _____

Full Name: _____ Date of Birth: _____ / _____ / _____

Legal Gaurdian's Name: _____

(If younger than 18)

Member ID Card Number: _____ Phone Number: _____

Address: _____

(Including City, State and Zip)

Signature of Member, Caregiver or Guardian: _____

(If signed by Caregiver or Guardian, a Personal Representative Form or other legal document must be on file with the Plan.)

New Primary Care Provider (PCP) Information

Name of PCP: _____

PCP Practice Tax ID Name: _____

Address: _____

(Including City, State and Zip)

Phone Number: _____ Fax Number: _____

Provider ID/NPI Number: _____

Provider Practice Tax ID Number: _____

For Office Use Only

Name of PCP Office Staff Member Processing Request: _____

Please Mail or fax completed form to:

BlueCross BlueShield of Tennessee Fax: (423) 535-5498
Medicare Advantage Operations
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

Note: Please allow up to 4-6 weeks for change to be reflected in the Quality Care Rewards application located in Availity®.