

Member Data Change Form
For Member Contact Information & PCP Change Requests

Part 1: Member Information **PLEASE COMPLETE ALL HIGHLIGHTED AREAS**

Please provide the member's information:

* = required field

YOUR CHILD'S INFORMATION

(Last Name)*	(First Name)*	(Middle Initial)

(Member Medicaid ID Number)*

(Member Date of Birth)

(Current Street Address)	(City)	(Zip Code)

(Contact Phone Number)*

Part 2: PCP Change Request

Please provide PCP information: (only complete if member would like to change PCPs)

* = required field

(Requested PCP Full Name)*	(PCP Provider ID)*

(Office Address)*	(City)	(Zip Code)

(Office Phone)*

*** Reason for Change from Assigned PCP:**

- | | |
|---|--|
| <input type="checkbox"/> Already a patient with Requested PCP | <input type="checkbox"/> Office wait time too long for assigned PCP |
| <input type="checkbox"/> Requested PCP already sees family member | <input type="checkbox"/> Appointment wait time too long for assigned PCP |
| <input type="checkbox"/> Assigned PCP is too far | <input type="checkbox"/> Assigned PCP does not accept age |
| <input type="checkbox"/> Other _____ | |

(Signature of Member or Responsible Party)

(Date)

(Print Name of Responsible Party if Different from Member)

{ Birth Parent? Yes or No → If "No", the name of the "Responsible Party" must match exactly what Peach State has on file for "Responsible Party" or change cannot be processed.

Directions: Please fax Member Data Change forms, with a copy of the member ID card, if available, to Peach State Member Services Department at 1-800-659-7518. If you have questions about how to complete this form please call the Member Services Department at 1-800-704-1484.