Primary Care Physician (PCP) Selection/Change Form

Choosing a primary care physician is a requirement of your plan. If you do not choose one, one will be assigned to each plan member. You may submit this form via mail or fax (see bottom of form) or complete this form online by visiting www.providrscare.net/pcp-selection-change-form/. You can also call ProviDRs Care Customer Service, 800-801-9772 and select option 2 for assistance. **NOTE: Forms not signed or completed correctly will not be processed and your PCP selection or change will not occur.** To find a NexUS PCP visit www.ProviDRsCare.net and follow the steps to Find a Doctor. After entering your group number or "NexUS" select "Tier 1 Primary Care Physicians" to view a list of our Tier 1 Physicians.

Part 1: Member Information *(Please provide the plan member's information and print clearly)*

☐ New PCP Selection Effective Date: _____

☐ Change of PCP - Your request will be effective the first of the month following the receipt of your request.

Part 2: Member Information *(Please provide the plan member's information and print clearly)*

Employer Name:		Employer #:
Member Last Name	Member First Name	Member Middle Initial
Member Medical Plan ID#	Member Phone# (with area code)	Member Date of Birth (MM/DD/YYYY)

Part 3: PCP Selection/Change Information *(Please provide information about your PCP and print clearly)*

Plan Member Name (Last, First Name)	Physician Name	Physician Address	Non-Kansas Resident
			☐
Spouse Name (Last, First Name if applicable)	Physician Name	Physician Address	☐
Dependent 1 Name (Last, First Name)	Physician Name	Physician Address	☐
Dependent 2 Name (Last, First Name)	Physician Name	Physician Address	☐
Dependent 3 Name (Last, First Name)	Physician Name	Physician Address	☐
Dependent 4 Name (Last, First Name)	Physician Name	Physician Address	☐

If you need to list additional dependents, please continue on the back or call 800-801-9772 and select option 2 for assistance.

Part 4: If making a change, specify reason (please check one of the boxes below):

☐ Already a patient with requested PCP
☐ Different primary care provider preferred
☐ Convenient location and/or hours
☐ Referred by family/friend
☐ Unsatisfied with assigned PCP
☐ Other (please specify below):

Print name of Member or responsible party	Date (MM/DD/YYYY)
Signature of Member or responsible party	

Mail completed form to: 238 N Waco Wichita KS 67202 or
fax completed form to: 683-6255.