



PCP Change Form

This form *will not be processed* if the signature of the member or his/her parent or guardian is not supplied below.

Today's Date: _____

To Be Completed by the Member

Member ID#: _____

Member Name: _____
(Please print)

Parent/Guardian Name: _____
(if applicable) (Please print)

Reason for Changing PCP: _____

Signature of Member
or Parent/Guardian: _____
(Signature required)

Name of New Medical PCP: _____

Name of New **OB/GYN**: _____

Effective Date of Change: _____ First day of the upcoming month

Fax the completed form to Customer Service:

Univera Healthcare (716) 857-4610 or 1 (800) 742-6153

Univera Community Health 1 (888) 273-8296

(Rev. 12/11)

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