Primary Care Provider Selection Form

TO BE COMPLETED BY PROVIDER OR AMERIHEALTH CARITAS IOWA (ACIA) STAFF MEMBER:

Provider Contact & Phone: ____________________

Provider Name: ____________________

Provider ID#: ____________________

Provider Address: ____________________

TO BE COMPLETED BY ACIA MEMBER:

Member Name: ____________________

Member Birth Date: __________ **Member Social Security No.** __________

ACIA Member ID# : __________ **Medicaid ID #:** __________

Member Address: ____________________

Appointment Date: ____________________

Reason for Change: ____________________

I request that the above named provider be assigned as my/my child's PCP effective today.

________	____________________	____________________
Date	**Name**	**Patient/Member or Guardian Signature**

Provider to fax to: Provider Transfer Fax
AmeriHealth Caritas Iowa
1-844-214-2468
Label on cover sheet "Urgent Provider Transfer."

Provider Questions: Contact Provider Services at **1-844-411-0579**.

Member Questions: Contact Member Services at **1-855-332-2440**.

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