



POLK HEALTHCARE PLAN
Member/Social Services Section

RISK MANAGEMENT DIVISION
2135 Marshall Edwards Drive - Bartow, Florida 33830
Phone (863) 534-5387
Facsimile: (863) 519-7938

PCP CHANGE REQUEST FORM

MEMBER NAME: _____ CASE #: _____

MAILING ADDRESS: _____ SS #: _____
_____ PHONE #: _____

I am requesting to change my primary care doctor from Dr. _____ to Dr. _____.

My reason for requesting this change is: _____

_____.

I understand that if the change is approved, the Plan will send me a new Plan ID card that lists my new PCP and that the new doctor change will only take effect on the first day of the month following my written request. I also understand my request must be received, by your office, by the 25th day of the month in order for the change to become effective the next month. Once I am approved, I will get a new Plan ID card 10 to 15 days after you have received my request indicating the new PCP.

Member Signature Date