

Change Primary Care Provider Request Form



Please fill out and fax to: 888-205-9851

PLEASE PRINT

Member ID _____ Date of birth (month/day/year) _____

Member Name: First _____ MI _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone number _____ Signature _____

ID card will be mailed to the last reported address at TennCare. If you have recently moved, please contact the Family Assistance Service Center at 866-311-4287.

This information must be filled out or change request will not be done.

Is your provider panel open to new TennCare patients ___ Yes No

already an established patient with our office.
If Provider Panel is closed please indicate reason for adding the patient to closed panel.

New Primary Care Provider _____

1607 Westgate Circle Suite 200

Address _____

Brentwood TN 37027

City _____ State _____ Zip _____

(615) 376-8195 (615) 376-2601

Phone number _____ Fax number _____

621864820

Nine digit TAX ID# _____ Two digit suffix: _____

Physician signature _____ Date _____

Please fax only this page to the number above.

8 Cadillac Drive, Suite 100, Brentwood, TN 37027
800-690-1606 UHCCommunityPlan.com