

Primary Care Provider (PCP) Change Request Form

Members may change their PCP for any reason, at any time. Please be aware that a PCP change may limit the member to specific specialists or hospitals to which the new PCP refers (i.e., sub-network, referral circles).

Instructions

Provide all requested information to ensure timely processing. The change will take place within 48 hours after request is received. For urgent requests, call Gold Kidney Health Plan Member Services at **(844) 294-6535**.

There are three options available to members who wish to change their PCP:

- Complete and submit the PCP Change Request form to GKMemberServices@goldkidney.com.
- Call Gold Kidney Health Plan Member Services at (844) 294-6535.
- For members only: update your primary care provider through the Gold Kidney Member Portal.

Submit completed forms to Gold Kidney Health Plan at [**GKMemberServices@goldkidney.com**](mailto:GKMemberServices@goldkidney.com).

| Member Information | | |
|---|--|-------|
| Last Name: | First Name: | MI: |
| Gold Kidney Member ID: | Date of Birth: | |
| Address: | | |
| City: | State: | ZIP: |
| Phone Number: | Email: | |
| Current PCP Practice Name: | | |
| Reason for Change <i>(check one)</i> | | |
| <input type="checkbox"/> Member or PCP relocation | <input type="checkbox"/> PCP Office Inconvenient | |
| <input type="checkbox"/> Patient is already established | <input type="checkbox"/> Member Choice | |
| <input type="checkbox"/> Other (please describe): | | |
| New PCP Information | | |
| New PCP Practice/Group Name: | | |
| New PCP Full Name: | | |
| PCP NPI: | PCP Tax ID: | |
| PCP Street Address: | | |
| City: | State: | ZIP: |
| Fax Number: | Phone Number: | |
| Please note: if signed by Caregiver or Guardian, an Appointment of Representative Form or other legal document must be on file with the Plan. | | |
| Member, Caregiver, or Guardian Signature: | | Date: |
| PCP Representative Signature: | | Date: |
| For PCP Completion, if member signature was not obtained | | |
| <input type="checkbox"/> I, _____, attest in good faith that I have had direct interaction with the member regarding this PCP change request and verbal consent from the member, caregiver, or guardian was obtained. | | |