Specialist as PCP Request Form

Date of Request:
Member Name:
Member ID Number:
Member Phone Number:
Member Address:
PCP on Record:
Member Diagnosis:
Clinical Data:
By signing this form, you agree to accept responsibility for the coordination of all the enrollee's health care needs. **Specialist Signature:**
Member Signature:
Member Reason for Requesting Specialist as PCP:
Approved: ☐ **Yes** ☐ **No**
Signature of CMD or MD:
INTERNAL AMBETTER HEALTH USE ONLY
Date Received in Medical Management: **Date Sent to Member Services:**
Date Sent to Provider Services:

Referral Authorization Number: 1-877-687-1196

Please fax completed form to Ambetter from Superior HealthPlan, Medical Management at 1-855-537-3447.

Ambetter.SuperiorHealthPlan.com