

Primary Care by Specialist Request Form

Member's name Date of birth Member number

Parent/guardian's name Primary HMO PCP name

Specialist name Specialty

Diagnosis

Please write a brief description of the reasons you would like the specialist to provide primary care.

I request the above change and hereby give the specialist noted and my current primary care physician permission to release medical records that may be needed in support of my request.

Member (if over 18)/Parent or guardian

Date signed

I certify that it is medically necessary for me to be this member's primary care physician and that I will provide primary care services for this member to include coordination of all the member's health care needs, preventive care examinations, immunizations, and treatment of minor intercurrent illnesses. I further certify that I will accept the same contractual obligations, rates, and payment methodologies as the primary care provider.

Specialist's signature

Date signed

Specialist's telephone number

FAX TO TCHP AT (832)-825-8750

Date received: _____

Date notified of decision: _____

Review by Medical Director

Approved Denied

List reason:

Signature, Medical Director

Date