UNIVERSITY of MARYLAND HEALTH PARTNERS

Primary Care Provider (PCP) Change Form

Fax to: 410-840-7493

Please use this form to assign members to your practice.

Section 1 – Member Information		
Member Name:	**Member ID:**	
Member Mailing Address:		
City:	**State:**	**ZIP:**
Member Phone:	**DOB:**	**Date of Change:**

Signature of Member/Legal Guardian: _____

Section 2 – Provider Information		
Group/Practice Name:	**PCP Name:**	
TIN:	**NPI:**	
Practice Address:		
City:	**State:**	**ZIP:**
Phone:	**Fax:**	
Completed by:		

Member Services: 410-779-9369 / 800-730-8530