JOHNS HOPKINS
HEALTH PLANS

P.O. Box 3538
Scranton, PA 18505

Primary Care Provider Change Form (Advantage MD)

FOR PROVIDER USE ONLY

Complete this form and fax to the Enrollment Department at 1-855-206-9203 or return by mail.

* Required information

***Date:**

Member information			
***First Name**	***Last Name**		***Birthdate**
Member address	**City**	**State**	**Zip**
***Member ID #**			☐ HMO ☐ PPO
Member (Patient) or Power of Attorney Signature			

New Provider Information:	
Primary Care Provider/Site Name	***NPI #**
Provider ID Number	**Patient is being seen today** ☐Yes ☐No
PCP Site Staff Member Name	
Staff Member Phone #	
Provider Change Effective Date	