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.

P.O. Box 3538
Scranton, PA 18505

* 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	