7231 Parkway Drive, Suite 100
Hanover, MD 21076

Primary Care Provider Change Form (Uniformed Services Family Health Plan)

FOR PROVIDER USE ONLY

Complete this form and fax to the Enrollment Department at 410-424-4770 or return by mail.

* Required information

***Date:**

Member information:				
***First Name**:	***Last Name**:		***Birthdate:**	
Member address:	**City**:	**State**:	**Zip**:	
***Member ID#**:				
Member (Patient) or Parent or Guardian Signature:				

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

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