



PCP REQUEST FOR TRANSFER OF MEMBER

Med Rec # _____

Physician: _____ Member: _____

ID#: _____ ID#: _____

Telephone: _____ Telephone: _____

Fax: _____ Commercial Medicare Medicaid

Please include detailed reason for request:

Disruptive behavior Non-compliance with treatment

Missed appointment: Date: _____ Date: _____ Date: _____

Other: _____

Description:

Please submit a copy of the progress notes from the member's medical record that documents your concern.

Physician signature: _____ Date: _____

Instructions:

Complete this request in its entirety and attach all supporting documentation, including pertinent medical records and office notes. Requests to transfer a member from your care should not be discussed with the member until approval is received from the Plan.

Submit request to:

**8735 Henderson Rd, Ren 2
Tampa, FL 33634
Or fax to Member Services at: (877) 297-3112**

Section to be completed by the Plan

Medical Director: _____

Date Received: _____ Date Closed: _____ New PCP Assignment: _____

CSCL # _____