Primary Care Provider (PCP) Selection Form
SOUTHERN REGION:
Lake, Marin, Mendocino, Napa, Solano, Sonoma and Yolo Counties

Please fill out this form for yourself and each member of your family who has Medi-Cal. Use PHC's list of Primary Care Providers (PCPs) to pick your PCP.

Last Name	First Name	Date of Birth			Medi-Cal ID # or Social Security No.
		MO	Day	Yr	

Name of Doctor or Medical Group	Provider # of Doctor or Medical Group	Provider's Phone Number

Last Name	First Name	Date of Birth			Medi-Cal ID # or Social Security No.
		MO	Day	Yr	

Name of Doctor or Medical Group	Provider # of Doctor or Medical Group	Provider's Phone Number

1. Provide the following information for anyone listed on this form who is pregnant:

   Name: _____ Due Date: _____

2. I understand that I have a choice of Primary Care Providers (PCPs) that are contracted with Partnership HealthPlan of California (PHC).
3. I understand that if I do not choose a PCP, PHC will assign one to me.
4. I understand that I can change my PCP and that the change will be effective the first of the month after the change was requested.

To ensure that we have the most current information, please provide current mailing address:

Address: _____ City: _____

Zip Code: _____ Phone Number: _____

E-mail Address: _____

How would you like to receive your PHC Member Newsletter? □ E-Mail □ Regular Mail

PHC is required to report your address and phone number changes to your county's Medi-Cal office. This excludes members receiving SSI benefits.

Signature: _____ Date: _____

Return to: Partnership HealthPlan of California, 4665 Business Center Drive, Fairfield, CA 94534 or you can fax to **(707) 863-4415**.