Primary Care Provider (PCP) Selection Form

How to choose your primary care provider (PCP)

1. Fill in all shaded areas of this form for all family members listed.
2. Pick 2 PCPs for each family member from the Provider Directory. Pick 2 PCPs that are accepting new patients.
3. Write the PCP names and their numbers in the shaded areas.
4. Sign this Form. Unfortunately, we cannot process unsigned forms.

If you want a PCP that is not accepting new patients or if you have any questions, please call us at **(800) 863-4155.**

TTY/TDD users can call the California Relay Service at **(800) 735-2929** or call **711.**

<<First Name>> <<Last Name>> <<ID Number>> <<Date of Birth>>

PCP Selection

Name of PCP – 1st Choice ______________ PCP# from Provider Directory ______________

Name of PCP – 2nd Choice ______________ PCP# from Provider Directory ______________

<<First Name>> <<Last Name>> <<ID Number>> <<Date of Birth>>

PCP Selection

Name of PCP – 1st Choice ______________ PCP# from Provider Directory ______________

Name of PCP – 2nd Choice ______________ PCP# from Provider Directory ______________

<<First Name>> <<Last Name>> <<ID Number>> <<Date of Birth>>

PCP Selection

Name of PCP – 1st Choice ______________ PCP# from Provider Directory ______________

Name of PCP – 2nd Choice ______________ PCP# from Provider Directory ______________

<<First Name>> <<Last Name>> <<ID Number>> <<Date of Birth>>

PCP Selection

Name of PCP – 1st Choice ______________ PCP# from Provider Directory ______________

Name of PCP – 2nd Choice ______________ PCP# from Provider Directory ______________

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

Name: ______________ Due Date: ______________

Email Address: ______________

If the address printed on your envelope is incorrect, please fill in your current mailing address:

Address: ______________ City: ______________

Zip Code: ______________ Phone Number: ______________

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

I understand that if I do not choose a PCP, PHC will assign one to me.

Signature: ______________ Date: ______________

Return to: **Partnership HealthPlan of California, 4665 Business Center Drive, Fairfield, CA 94534** MC1015ES

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