



For acceptance of an established patient to a physician panel.

(1) Physician Name:	
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TO BE COMPLETED BY MEMBER

(2) Member Name	(3) ID/SSN	(4) Date of Birth

(5) PRIMARY CARE CHANGE REQUEST

<i>If accepted, I would like my Primary Care Physician to be the one listed above.</i>	Member Signature and Date:
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TO BE COMPLETED BY PHYSICIAN OFFICE

(6) Physician Office Use Only (circle one)	(7) Effective Date (circle one)	(8) Notes:
ACCEPT / REJECT	Effective Immediately / Other Date: _____	

(9) AUTHORIZING INFORMATION

Name and Title of Authorizing Individual:	
Date:	Signature:

Directions for Members:

1. Complete boxes 1 – 5 of the form and send it to the physician’s office you would like to select. Ask the office if they will accept your assignment by circling the appropriate response and then return the form to us at: Health First Health Plans, Attn: Customer Service Dept, 6450 US Highway 1, Rockledge, FL 32955.

Directions for Physician Offices:

1. Circle your acceptance or rejection of this assignment in Box 6. If accepted, include the effective date of the assignment and any notes you would like to add. Please be sure to include a signature and date.
2. Fax the completed form to Health First Health Plans at (321) 434-4362 or send to: Health First Health Plans, 6450 US Highway 1, Rockledge, Florida 32955

CONTACT CUSTOMER SERVICE FOR ASSISTANCE

7 Days a week from 8 a.m. to 8 p.m.

(321) 434-5665 or (800) 716-7737

For TDD Relay for the hearing impaired, contact (800) 955-8771 during the same hours.

Duplicate copies of this form are also available at www.healthfirsthealthplans.org.