Primary Care Provider Selection Form

Forms must include:

- All member information; name, date of birth, member's Partnership or Medi-Cal ID number
- Name of doctor or medical group and the primary care provider (PCP) number (listed in our provider directory)
- Member's signature and date, OR an authorized representative's signature and date

Fax completed forms to (707) 863-4415.

Please have the member fill out this form for themselves and for each family member who has Medi-Cal. Use Partnership's list to choose a new doctor and to find their ID number.

Last Name	First Name	Date of Birth			Member's Partnership or Medi-Cal ID Number
		Mo	Day	Yr	
Name of Doctor or Medical Group	PCP #				Doctor's Phone Number

Last Name	First Name	Date of Birth			Member's Partnership or Medi-Cal ID Number
		Mo	Day	Yr	
Name of Doctor or Medical Group	PCP #				Doctor's Phone Number

1. Give name and due date of anyone listed on this form who is pregnant:

   Name: _____ Due Date: _____

2. I know that I have a choice of doctors with Partnership HealthPlan of California.

3. I know that I can change my doctor. I also know that the change will start on the first of the month after I give my form to Partnership.

To make sure that we have the most up-to-date information, please give your mailing address:

Address: _____ City: _____

Zip Code: _____ Phone Number: _____

E-mail Address: _____

How would you like to get your Partnership Member Newsletter? □ E-Mail □ Regular Mail

Partnership must send address and phone number changes to your county's Medi-Cal office. This does not include members who get SSI benefits.

Signature: _____ Date: _____