

PCP Request for  
Transfer of Member Form



Med Rec # \_\_\_\_\_

Physician: \_\_\_\_\_ Member: \_\_\_\_\_  
ID#: \_\_\_\_\_ ID#: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_

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**

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Section to be completed by the Plan

Medical Director: \_\_\_\_\_

Date Received: \_\_\_\_\_    Date Closed: \_\_\_\_\_    New PCP Assignment: \_\_\_\_\_

CSCL # \_\_\_\_\_