PCP CONSENT FORM

For OB/GYN or Pediatric Sub-specialists ONLY

An Independent Licensee of the Blue Cross and Blue Shield Association

To select a designated PCP who is an **OB/GYN** or **Pediatric Sub-specialist** practitioner, a member with a PCP Coordinated Care HMO Plan must get prior consent from the provider. The OB/GYN or Pediatric sub-specialist provider must be in network for the member's benefit plan and must complete, sign and return this form for approval to BCBSAZ at the fax number or email address shown at the bottom of the form.

1. REQUIRED MEMBER INFORMATION

Member Information (for patient requesting the Designated PCP)			
Last Name	First Name		Middle Name
Member ID (from the ID Card)	Phone Number		
Address	City	State	Zip Code

2. THE REQUESTED OB/GYN OR PEDIATRIC SUB-SPECIALIST PROVIDER must complete and sign this section, giving consent to serve as PCP for the above member. Email or fax this form to BCBSAZ for approval (see below).

Provider Information (for OB/GYN or Pediatric sub-specialist that the member wants as PCP)			
Last Name	First Name		Middle Name
Office Location	City	State	Zip Code
Specialty	NPI Number	Tax ID Number	

Agreement Terms

By signing below, the OB/GYN or Pediatric Sub-specialist provider acknowledges that he/she is contracted for participation in the network associated with the member's benefit plan, and understands that a member's designated PCP is expected to do the following:

1. Provide all primary care services for the member (in addition to services relating to your specialty)
2. Submit referral requests for the member's office visits with other specialists, if a referral is required
3. Be familiar with expanded precertification requirements
4. Coordinate the member's overall care and close any care gaps
5. Facilitate appropriate access to specialist care and services
6. Document an assessment for treatment regimen for all acute, chronic and preventive conditions
7. Engage with the BCBSAZ Care Management program as needed
8. Encourage use of BCBSAZ health and wellness tools
9. Provide patient/family education as needed
10. When acting as a member's designated PCP, collect only PCP cost share from the member (not specialist cost share)

Note: OB/GYN and Pediatric sub-specialists will not be displayed as PCPs in the provider directory.

Authorized Consent

I am ______________________________, the chosen designated provider. I agree that by entering my name in the [electronic] signature field below, I am accepting the designated PCP responsibilities indicated above for the patient(s) specified on this form.

/s/ Authorized [Electronic] Signature	Date

3. PROVIDER: Please Sign, SAVE, attach and email this PCP Consent Form to: ProvNet@azblue.com

Or **fax the form** to: BCBSAZ Network Management **(602) 864-3142**

For BCBSAZ Use Only	
☐ In network for the member's benefit plan	☐ Approve request
☐ Verified Credentialed Specialty	☐ Deny request: Reason

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