Primary Care Provider Selection Form

To pick or change your primary care provider (PCP), fill out this form:

1. Provide all member information i.e. name, date of birth, and Partnership or Medi-Cal ID number.
2. Write the PCP name and PCP number listed in our Provider Directory.
3. Member or authorized representative must sign this form.
4. Fax completed form to **(707) 863-4415**.

First and last name: _____

Date of birth: _____ Partnership ID number: _____

Name of PCP: _____ PCP#: _____

First and last name: _____

Date of birth: _____ Partnership ID number: _____

Name of PCP: _____ PCP#: _____

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Name of PCP: _____ PCP#: _____

First and last name: _____

Date of birth: _____ Partnership ID number: _____

Name of PCP: _____ PCP#: _____

If anyone listed on this form is pregnant, please give their name and due date below.

Name: _____ Due date: _____

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Please fill in your current mailing address:

Address: _____

City: _____ Zip code: _____

Phone number: _____

E-mail address: _____

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

Members have a choice of PCP with Partnership on our website PartnershipHP.org. PCP changes start on the first of the month after Partnership receives your form or request.

We are here to help you. Call us at **(800) 863-4155,** Monday – Friday, 8 a.m. to 5 p.m., if you have any questions or concerns. TTY users can call the California Relay Service at **(800) 735-2929** or call **711**.

Signature: _____ Date: _____

All forms must be signed to be processed.