



**MEMBER PCP TRANSFER REQUEST FORM**

*60 Calendar Days Notice Required*

Date: \_\_\_\_\_

**PCP Information**

PCP Name: \_\_\_\_\_

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

**Member Information**

Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

**Reason for member transfer:**

- Multiple no shows  Member relocated  
 Dates of no show appointments and department: \_\_\_\_\_  
 Dates of appointments kept and department: \_\_\_\_\_

- Unsuccessful contact with member  Non-compliant with medical treatment
- Behavioral concerns (safety issues)  Verbal/physical abuse or altercation  
 Please specify: \_\_\_\_\_

**Medical issues:**

- Asthma     Diabetes     High blood pressure     Pregnancy     Substance abuse
- Other (please specify): \_\_\_\_\_

**Additional Information:**

*(Include specific information that would help the BMC HealthNet Plan outreach effort).*

\_\_\_\_\_  
\_\_\_\_\_

*Please provide documentation of appointments, and dates and types of outreach activities conducted by the provider. BMC HealthNet Plan will outreach to the member to determine the reason for missed appointments or non-compliance, and will provide a transition plan to ensure there is no interruption in care or services.*

**FAX COMPLETED FORM TO:    (617) 897-0838    Attn: Enrollment**