Primary Care Provider (PCP) Change Form

This change becomes effective the first of the month following the date we get your request.

Member Information	
Member's Name:	
Date of Birth:	Member ID Number:
Member Phone Number:	Member Email Address:
New PCP:	

Member Information #2	
Member's Name:	
Date of Birth:	Member ID Number:
Member Phone Number:	Member Email Address:
New PCP:	

Member Information #3	
Member's Name:	
Date of Birth:	Member ID Number:
Member Phone Number:	Member Email Address:
New PCP:	

Reason for Change

- I've moved
- PCP moved
- PCP left practice
- Office location is hard to get to
- PCP no longer with AlohaCare
- Did not want PCP I was assigned
- Personal preference
- Communication problems with PCP/office staff
- Hard time getting appointments
- Wait time in the office too long
- Not satisfied with the office staff
- PCP/office staff rude or annoying
- Poor quality of medical care

Authorization for Primary Care Provider Change		
I authorize AlohaCare to make the changes indicated above for me (and my dependents). I understand that I must sign and date this form before it will be processed. AlohaCare requires proper handling of personal health information for our members. Details of our confidentiality policies and procedures are available upon request. Self Parent of a minor child Power of attorney Legal guardian		
Print Name	Signature	Date

Mail completed form to: AlohaCare
Attn: Member Services
1357 Kapiolani Blvd., Ste 1250
Honolulu, HI 96814

Or Fax completed form to (808) 973-3810