

**Arkansas Medicaid Primary Care Case Management Program  
Primary Care Provider Selection and Change Form**

**Member Information:**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Medicaid ID# \_\_\_\_\_ Social Security # \_\_\_\_\_

Birth Date \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_

**Requested New Doctor (Primary Care Provider):**

I have picked the three (3) providers named below in order of my preference to be my primary care provider. I understand only one (1) of them will be my primary care provider.

- |    |                                |                       |                    |
|----|--------------------------------|-----------------------|--------------------|
| 1. | _____                          | _____                 | _____              |
|    | Provider's first and last name | Medicaid Provider ID# | Date of assignment |
| 2. | _____                          | _____                 | _____              |
|    | Provider's first and last name | Medicaid Provider ID# | Date of assignment |
| 3. | _____                          | _____                 | _____              |
|    | Provider's first and last name | Medicaid Provider ID# | Date of assignment |

**Reason for Request to Assign/Change Doctor (Primary Care Provider)  
Choose all that apply. Select at least one.**

- New Member – made 1st time selection
- Already patient with requested PCP
- Requested PCP already sees family member
- Member preference
- Member moved
- PCP hours didn't fit member need
- Quality of care
- Office wait times are too long
- Takes too long to get an appointment
- Office too far away/ hard to get to
- Language / communication barrier
- Other (please specify) \_\_\_\_\_

**Signatures:**

Member Signature (or Legal Guardian if a minor) \_\_\_\_\_

Printed Name of Member (or Legal Guardian if a minor) \_\_\_\_\_

Date \_\_\_\_\_