HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Primary Care Physician Change Request Form

(To be completed by the Member)

(Please Print Clearly)

Member Name: _____ **Date of Birth**: _____

Member Number: _____ **Phone Number**: _____

Member Signature: _____ **Date**: _____

Current Primary Care Physician

Name: _____Group/Location: _____

New Primary Care Physician

Name: _____Group/Location: _____

Effective Date of New Primary Care Physician: _____

Reason for Change: _____

Staff Name: _____ **Date:** _____
(Please Print)

Staff Signature: _____ **Phone Number:** _____

Please submit copy to Health Plan of Nevada at:

Health Plan of Nevada, Inc.
Attn: Member Services Correspondence
2720 N. Tenaya Way
Las Vegas, NV 89128

Or

Fax: (702) 240-6281

All change requests are subject to verification and provider availability.