

REQUEST FOR CIVILIAN PRIMARY CARE MANAGER/DISENROLLMENT FORM

1. Names of family members requesting a civilian primary care manager: _____

2. Sponsor's Social Security Number: _____

3. Home address: _____
(Street, City, State, Zip code)

4. Home Phone: () _____ - _____

5. Reason you are requesting a civilian primary care manager: *(If for specific medical reasons, please provide documentation of condition.)*

6. Who is the civilian provider you are requesting to be your primary care manager? _____

7. Do you have any other civilian health insurance? No Yes: _____

8. Do you drive? No Yes

9. Do you have access to public transportation? No Yes

(Requestor's signature)

FOR FACILITY USE ONLY

1. Date received: _____

2. Family lives inside outside the 20 mile/30 minute catchment area per Sierra web site.

3. Patient's appointment history is attached. Yes No

4. Patient's complaint history is attached. Yes No

5. Signature of Chief, Department of Primary Care: _____

6. Final approval is granted denied.

7. Signature of approving authority: _____