

PRIMARY CARE MANAGER (PCM) CHANGE REQUEST FORM (FOR PROVIDERS)

(See DD Form 2005 for Privacy Act information.)

Section I - To be completed by the provider

1. I have personally reviewed the outpatient medical record and or spoken with the patient and request a change of PCM for the following reason:

Patient requires a higher level of care Other (specify):

2. The patient requires the following level of care: FNP or PA Internist Family Practice Physician Pediatrician

3. The medical condition(s) that require(s) a higher level of care include(s) the following:

4a. Current PCM's printed name or stamp	4b. Current PCM's signature	4c. Date
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4d. Current PCM's team: Pediatrics Red Team, Family Care Center White Team, Family Care Center Blue Team, Family Care Center

5a. OIC or team medical director <input type="checkbox"/> Concur <input type="checkbox"/> Nonconcur Signature:	5b. Date
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6a. Chief, Department of Primary Care <input type="checkbox"/> Concur <input type="checkbox"/> Nonconcur Signature:	6b. Date
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Section II - To be completed by the patient

7. Patient's name (<i>Last, First, Middle</i>)	8. Sponsor's name (<i>Last, First Middle</i>)
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9. Family number prefix	10. Sponsor's social security number	11. Home phone (<i>include area code</i>)	12. Work phone (<i>include area code</i>)
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13a. Street address	13b. City, State, Zip Code
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14. Request I be changed to one of the two providers I have listed below:	
14a. First choice	14b. Second choice

15a. Patient's certification of understanding I understand that my primary care manager is requesting a change in the provider assigned to me. I also understand that while Kimbrough Ambulatory Care Center will guarantee that I am assigned to the appropriate level of care, it may not always be possible to assign me to my first choice in providers.

15b. Patient's printed name	15c. Patient's signature	15d. Date
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Patient: Do not sign in block 15c until you have read the statement in block 15a.