Specialist as PCP Request Form

Date of Request:	**Date Received in MM:**
Member Name:	
Member ID Number:	
Member Phone Number:	
Member Address:	
PCP on Record:	
Member Diagnosis:	
Clinical Data:	
Specialist Signature:	
Member Signature:	
Member Reason for Requesting Specialist as PCP:	
Approved: ☐ **Yes** ☐ **No**	
Signature of CMD or MD:	
INTERNAL USE ONLY **Date Sent to Member Services:**	
Date Sent to Provider Services:	

Note: Referral Authorization Number - 1-800-218-7508

(Form may be used for any Superior HealthPlan programs, as applicable.)

Please fax completed form to Superior HealthPlan, Medical Management at 1-800-690-7030.

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