Specialist as PCP Request Form

Date of Request:	
Member Name:	
Member ID Number:	
Member Phone Number:	
Member Address:	
PCP on Record:	
Member Diagnosis:	
Clinical Data:	
By signing this form, you agree to accept responsibility for the coordination of all the enrollee's health care needs. Specialist Signature:	
Member Signature:	
Member Reason for Requesting Specialist as PCP:	
Approved: ☐ Yes ☐ No	
Signature of CMD or MD:	
INTERNAL SUPERIOR HEALTHPLAN USE ONLY	
Date Received in Medical Management:	Date Sent to Member Services:
Date Sent to Provider Services:	

Referral Authorization Number: 1-800-218-7508

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

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