FIDELIS CARE™

Request Primary Care Physician Change

From: ______________________ ___161531979___________
Sender's Name (printed) Practice Tax ID

CapitalCare Medical Group _____(518) 641-6850______
Practice Name (printed) Practice Fax# (required)

Fax To: Fidelis Care New York
Member Services Department
Rego Park, New York
Fax#: **718-393-6635**
Date: ____________________________________
Patient: _____________________________________
Fidelis ID#: _____________________________________
Medicaid #: _____________________________________

Effective today, I wish to change my Primary Care Physician from:

Dr. _____________________ to
(printed)
Dr. _____________________________________ Tax ID 161531979
(print first and last name)

___________________________ _____________________________
(Patient Signature) (Date)

Member: Have you seen any Primary Care Physician within this month?
________ **Yes** ________ **No**

If yes, who and when? __________________________________

- **In order for this form to be processed all fields must be completed.**
- **Always check your rosters or the 1-888-FIDELIS IVR system to ensure that the member is on your roster.**

CHP / CAID

3/31/2014
PR/MS Form