



Pt. Act# _____

PRIMARY CARE PHYSICIAN WAIVER

I, _____ DOB: ____/____/____ am a _____
(Patient Name) (CDPHP, BS, GHI/HMO)

member who is requesting treatment from _____.
(Physician's Name)

I understand that if I do not notify the insurance carrier listed above to change my PCP and/or OB/GYN provider to the provider listed above **within five (5) business days**, I will be financially responsible for the services rendered during this visit.

Signed: _____ Date: ____/____/____

Witnessed: _____ Date: ____/____/____

I, _____, DOB: ____/____/____ am a _____
(Patient Name) (Empire BC)

member who is requesting treatment from _____.
(Physician's Name)

I understand that if I do not notify the insurance carrier listed above to change my PCP and/or OB/GYN provider **TODAY** to the provider listed above, I will be financially responsible for the services rendered during this visit.

Signed: _____ Date: ____/____/____

Witnessed: _____ Date: ____/____/____